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## ORIGINAL ARTICLES.

### *CHOLELITHIASIS, WITH REPORT OF CASES.*

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THE importance of this subject seems to be just dawning upon the profession, and it is certain that its history, as written at the close of the next decade, will record one of the most brilliant epochs in surgery. When it is considered that on an average probably one out of every ten persons is at some period of life afflicted with gall-stones, the great frequency of pathologic processes of the biliary ducts, including the gall-bladder, will be appreciated. The old are most prone to have gall-stones, also persons the subject of preexisting disease in this region, such as cancer of the liver and adjacent structures. Women are more frequently affected than men—in the proportion of five to two. Tight-lacing has been considered a cause of cholelithiasis, but sedentary occupation with its attending torpor of secretion and excretion is probably largely responsible for this difference in the frequency of the affection in men and women.

The essential pathology of gall-stone formation consists in an altered condition of the mucous membrane of the bile passages. Once there is destruction of the epithelium, as from extension of inflammatory processes of the duodenum, or from invasion of the ducts by the bacillus coli communis, or from circulatory disturbances resulting from the mechanical pressure of growths, the conditions are at once created for a deposit of cholesterin, carbonate of lime, and bile pigment. The nucleus of such deposits, as well as much of the component mass, often consists of dead epithelial cells and inspissated mucus from the preexisting catarrhal inflammation. The well-known tendency of Americans to so-called gastric and duodenal catarrh, induced by peculiarities of living, such as rapid eating and exertion at a time when large quantities of food are still in the process of digestion, would seem to render them especially liable to this affection.

In detecting the presence of gall-stones too much stress must not be laid upon the presence or absence of jaundice. As a matter of fact most of the patients with gall-stones who apply to physicians for relief have never had jaundice; hence, in the past,

they received treatment for something else, the true nature of the disease never being recognized. Severe pain in the right hypochondrium and epigastrium followed by jaundice, which usually passes away in a few days, marks the passage of a gall-stone so plainly that no diagnostic skill is required to surmise the nature of the condition. Or, again, severe sudden pain followed by continuous jaundice usually indicates an impacted calculus in the common bile duct. These are matters of common observation, and need not be dwelt upon in dealing with the symptomatology of the disease. The point in recognizing gall-stones which most deserves consideration is, that such symptoms as have already been enumerated probably do not exist in more than one-tenth the number of cases which come under the observation of the physician. Many patients suffer years with gall-stones in the gall-bladder which are too large to pass the cystic duct; such calculi, of course, never become engaged in the common duct, and so jaundice is not produced. Such cases are most often characterized by attacks of pain, usually requiring several hours or days to attain the greatest severity, with a variable period of persistence, followed by complete relief, the pain subsiding rather suddenly. The explanation of such attacks is to be found in the occlusion of the cystic, or gall-bladder duct, by the stone or stones and the distension of the gall-bladder with mucus. As soon as the passage is cleared by shifting of the stones, the result of the paroxysmal efforts of the muscular gall-bladder, the mucus escapes into the common duct and quiet ensues until the occurrence of another attack.

The pathology of this condition is confined to the gall-bladder and its duct, and from the ease with which the affection may be dealt with, it is especially important to recognize it before the graver complications of common-duct obstruction ensue. During the attacks of cystic-duct obstruction a careful search will usually reveal the enlarged and distended gall-bladder. If we would carefully examine these patients, instead of following the routine practice or calling the disease an attack of colic or indigestion and giving a dose of morphin, we would often establish a diagnosis of gall-stones in the gall-bladder at a time when operation would give the most brilliant results, and at a time when such treatment may be truthfully said to be preventive of the dangers of gall-stones.

Another and very frequent form of this disease is that in which the stones are very small and very numerous. I have removed more than fourteen hundred distinct but small calculi from a gall-bladder. In such cases one or more stones are passed every day or every few days, and the cystic duct being much smaller than the common duct the little stones usually pass very easily without producing jaundice. However, they give rise to a slight pain and feeling of discomfort, especially in the epigastric region, which lasts from a few minutes to an hour or more. I believe that patients having this form of the affection have been given a large proportion of all the pepsin and other lauded digestive agents which have ever been manufactured.

To recapitulate this part of the subject: (1) We recognize the presence of gall-stones attended with sudden severe pain and jaundice, or by obstruction either temporary or permanent of the common duct; (2) calculi confined to the gall-bladder and cystic duct attended with periodic pain without jaundice and characterized by a tumor composed of the distended gall-bladder in its usual situation (such cystic accumulations vary in size from that of a hen's egg to that of the human head). Occasionally the cystic-duct obstruction fails to be relieved, and the greatly distended gall-bladder may rupture, or, what is most common, become inflamed and adherent to adjacent organs, or to the anterior parietes; (3) cases characterized by slight pain in the epigastrium of varying intensity and duration, but without tumor or jaundice.

In competent hands the surgery of the gall-bladder is to-day the most satisfactory in its results of all abdominal work, and when we reflect how often it could be made preventive of the dread consequences of calculus disease, it should urge us to a due appreciation of the great advantages to be derived from a recognition of gall-stones, if possible before jaundice has become a symptom.

A brief history of fourteen cases subjected to operation is appended. Of these the calculi occupied the gall-bladder, or cystic duct, or both, in thirteen patients. In one case the common duct was alone the seat of obstruction. This was the only fatal case in the series, and in it jaundice had existed during eight months.

**CASE I.**—Mrs. B., aged thirty-six years, the wife of a physician, presented a history of periodic pain of a very severe character in the hypogastric region. Examinations by many physicians failed to determine the cause of her sufferings. There was no jaundice. In the absence of anything more conclusive her trouble was finally diagnosed and treated as gastric neuralgia.

September 19, 1892, I was requested to see her in consultation with her physician and Dr. Scott. The latter, having seen her the previous day, made a diagnosis of over-distended gall-bladder from impaction of stones in the cystic duct. During this last attack, which was most severe, requiring partial chloroform anesthesia for three days, there was a slight degree of jaundice. On examination of the patient I could detect a small tumor, about three inches in length by two inches in width, in the region usually occupied by a distended gall-bladder.

Operation was performed the following day, September 20th. A vertical incision was made at the outer border of the right rectus muscle, extending from the costal arch down to the lowest point of the tumor. The gall-bladder was found very tense and free from adhesions. By aspiration two ounces of clear mucus was withdrawn. The gall-bladder was incised, and several large stones removed, mostly from the cystic duct. The last of these stones was so deeply placed as to impinge upon the common duct, thus causing the slight jaundice from which she suffered. The gall-bladder was stitched to the parietal peritoneum, drained with a rubber tube, and the abdomen closed. Her recovery was afebrile, rapid, and uneventful. Bile flowed freely through the fistula for ten days, after which time its discharge ceased. Her health has been perfect ever since.

**CASE II.**—Mrs. K., aged twenty-five years. Four weeks previously she had been seized with severe pain in the region of the stomach and gall-bladder, which lasted the greater portion of the night, and necessitated morphia, hypodermically, for its relief.

An incision was made as in Case I. The gall-bladder was found to be at least five inches in length and very tense; it was about the shape of a large sausage. The fundus was drawn up into the abdominal wound, a flat sponge placed behind it, and an incision made through which was evacuated about six ounces of clear mucus. Twenty-four calculi, varying in size from that of a small chestnut to a half pea, were removed from the gall-bladder and cystic duct. A drainage-tube was inserted after stitching the gall-bladder to the parietal wound. Bile flowed for about twelve days afterward from the fistula, when the latter closed spontaneously. The patient did not require any opiate, and made a rapid and complete recovery. She has since remained in excellent health.

**CASE III.**—Mrs. S., aged twenty-six years, the wife of a physician, had suffered three years with recurring paroxysms of pain. A small tumor was noticed two years before in the region of the gall-bladder, and it was attended with circumscribed peritonitis. The trouble at this time was thought to be mesenteric tuberculosis. The history was somewhat obscure. There had been marked impairment of the general health, with gradual enlargement of the tumor mentioned. Vomiting was a common symptom. There was no jaundice. The shape of the enlargement was not that of an over-distended gall-bladder, and, moreover, its situation was not typical, being too far to

the right and a little too high up. This enlargement was broadest at the base and not at the fundus. Cystic degeneration of the kidney had been diagnosed. After careful and repeated examination of the patient I believed the trouble to be calculus impaction in the cystic duct. Operation revealed an enlarged gall-bladder with numerous adhesions. The border of the liver was drawn down, very much thinned, and adherent over most of the tumor. The gall-bladder was found to contain three or four ounces of normal secretion. This was drawn off, and five very large calculi found impacted in the duct, causing complete occlusion. These calculi were quite as large as the largest chestnuts. The gall-bladder was stitched in the usual way to the abdominal parietes and drained. The patient made an uninterrupted recovery, and has since experienced the greatest improvement in general health.

CASE IV.<sup>1</sup>—The patient, a physician, aged thirty-two years, had always been very fat, his usual weight being 217 pounds. He presented a history of never having been ill until two years previously. While making a visit to a patient he was seized with severe pain in the region of the gall-bladder, which he at once thought was an attack of biliary colic. This lasted for some time, finally passing off. The subsequent history was that he had numerous attacks of the same kind but of varying severity. During the spring of 1894 he had an attack which was much more severe than usual, since which time he had almost constant pain and was incapacitated for performance of professional duties. Later in the spring he thought he detected an enlargement in the region of the gall-bladder. This became very tender. June 1st he took to his bed. He was under the treatment of his partner in practice. One day he felt, as he described it, something "give way," and he began vomiting large quantities of pus and bile, and actually vomited gall-stones. This was followed by several large bowel evacuations of the same fluid during the course of ten or twelve hours, and in the dejecta were numerous particles of gall-stone debris, together with about one and one-half ounces of sand-like material. His own diagnosis was proven by the operation to have been entirely correct, *viz.*; that he had an over-distended gall-bladder, which had become inflamed and adherent to the duodenum into which it had finally broken. After this "giving way," as he called it, he suffered the most intense pain; there was loss of appetite amounting almost to complete anorexia; there was constant pain which confined him to his bed; he became emaciated, falling off in weight to about 160 pounds. In the meantime, he contracted the morphin habit, and, during the late summer months, daily took six or seven grains of this drug when the pain was most severe.

<sup>1</sup> The history of this case is of great importance as showing the probable outcome in the majority, if left to themselves. It also proves that calculus impaction or other impermeable occlusion of the cystic duct must eventually lead to one of two things: Either rupture of the attenuated, over-distended gall-bladder into the peritoneal cavity occurs, followed by inflammation, suppuration, and adhesion to some part of the alimentary canal, or adhesion to the abdominal walls takes place, through which the contents of the gall-bladder are ultimately evacuated.

As I have said, his own diagnosis was absolutely correct, as was demonstrated by the operation, *viz.*: an obstructed gall-bladder containing calculi, adherent and fixed very high up toward the duodenum with which it had a fistulous communication—a natural cholecystenterostomy, but which, on account of the pathologic material still remaining, failed to give relief. Jaundice was present in varying degree from time to time throughout the course of the disease, and evidently corresponded to the passage of some of the calculous debris by way of the common duct. On opening the abdomen the first thing which came into view at the notch of the liver was a thick mass of adherent omentum. I incised this, and gently pushing it out of the way, came down to the under surface of the edge of the liver, but could not locate the gall-bladder. A hard mass was finally detected high up beneath the diaphragm, and after a great deal of trouble I finally isolated the gall-bladder, which was little larger than my thumb and enclosed by numerous adhesions. A further separation of the adhesions brought into view the attachment to the duodenum, it being very high up, probably above the point of entrance of the common duct. The adhesions to the duodenum were very firm. The question was, as I was working high up under the ribs, at least four inches from the point where I would have to make an attachment of the gall-bladder to the parietal peritoneum, whether or not I should carry out my original purpose and establish a fistula through which the debris could be discharged, and allow the communication between the gall-bladder and the duodenum to heal. After great difficulty I succeeded in getting the fundus of the gall-bladder down, and stitched it to the highest part of the wound, which was nearly in the middle line over about what would normally correspond to the situation of the pylorus. I scooped out a large number of small calculi and debris, and placed a drainage-tube in the wound, packing gauze around it, fearing, as there was much tension, that the sutures might give way. The patient rallied nicely from the operation, and on the second day great quantities of this sand-like material were discharged through the drainage-tube. On the third day the whole dressing was for the first time saturated with bile. While the pain continued during the first few days after the operation, yet it was much less marked, and by the sixth day the patient was quite comfortable. The wound healed; his general health is almost perfectly restored, and everything promises a complete recovery.

CASE V.—A woman, aged thirty years, was first seen in consultation. The history was that the patient had suffered more or less continuously with abdominal pain, with paroxysms of greater severity, for about one year. Jaundice was not present. There was some emaciation, and a tumor the size of a fetal head, occupying the gall-bladder region, was detected. A diagnosis of over-distended gall-bladder from obstruction of the cystic duct was reached.

The usual incision being made at the outer border of the right rectus muscle, there was disclosed the largest distended gall-bladder that I have ever seen,



it being quite as large as a child's head. The contents consisted simply of normal mucus. Its enormous weight had drawn it down on a line with the umbilicus. I incised the sac after drawing off part of the fluid, and, passing my finger down into it could at first feel nothing. Passing a finger down to the junction of the cystic and common ducts in the peritoneal cavity, I could feel a large calculus impacted at about the junction of the cystic with the common duct. On again putting my finger into the gall-bladder I could feel the stone, the folds of the duct intervening, but could not bring my finger in contact with it. After drawing up the gall-bladder and putting its walls on the stretch, I was barely able, with the tip of my little finger, to touch a small part of the surface of the stone, but could not move it. With the fingers of the left hand underneath and outside, I could not impart any motion to it. I felt sure there was a constriction on either side of the calculus, and it seemed positive that it was thoroughly impacted or encysted, as I was absolutely unable to move it by my first manipulations. Fully fifteen minutes were consumed in extracting the stone; several times it seemed necessary to incise the duct from the outside and in this way remove the calculus. Finally, however, the distal side of the duct was sufficiently dilated to allow the passage of the stone. The specimen looked much more like a urinary than a biliary calculus. It was very large and of a color that I have never seen before in a gall-stone, being almost white and extremely hard. The gall-bladder was stitched in the usual way, and bile flowed freely through the fistulous opening within eight hours after the operation. This continued for six or eight hours, when it ceased, and has never returned up to the present time, although a small fistula, discharging mucus, has remained. Adhesion of the stricture has probably occurred at the site of the stone, thus cutting off communication between the common duct and the gall-bladder. If the little mucus fistula persists, I shall enlarge the wound and excise the gall-bladder, which in this case can be of no use to the patient.

CASE VI.—A man, aged forty years, five years ago was seized with severe abdominal pain, which was diagnosed by the attending physician as being due to the passage of a gall-stone. Since that time he has had repeated attacks of a similar character, attended with slight jaundice. Within the past year he has not had jaundice, but the paroxysms of pain have been much more frequent than formerly. I saw him November 7, 1894, when he was confined to bed with severe and almost continuous pain in the region of the gall-bladder; temperature,  $101^{\circ}$  F.; pulse, 100, vomiting and loss of appetite being present. Examination revealed a large tumor below the margin of the ribs on the right side, very broad at its base, and extending as low as the umbilicus. This tumor was quite tender. A diagnosis of over-distended gall-bladder with inflammation was reached.

The usual incision was made. The omentum was found adherent to the fundus of the gall-bladder. The gall-bladder was intensely congested, and pre-

sented the evidence of an acute, engrafted upon a chronic, inflammation. Aspiration revealed the presence of pus. After protection with sponges, and having the patient turned upon his side, the gall-bladder was incised and three ounces of pus and twenty-five medium-sized calculi were extracted. There seemed to be complete occlusion of the cystic duct, all stones occupying the cavity of the gall-bladder. After irrigation and drainage of the latter it was sutured in the usual way.

The patient made an easy recovery, bile appearing in the wound on the fifth day. The fistula closed within a few weeks.

CASE VII.—Mrs. W., aged forty-four, married, had suffered a year with periodic pain in the epigastric region, usually lasting less than an hour and recurring almost daily, but with no definite regularity, and independent of any dietary restrictions. In fact, she had been treated during four months by the rest and milk treatment for indigestion. She was very nervous and tired of taking medicine for dyspepsia and gastralgia. February 13, 1896, an exploratory incision was made in the median line above the umbilicus. No abnormality of the stomach was found. The gall-bladder was filled with small calculi. Cholecystostomy was performed. The patient made a prompt recovery, with cure of the gastralgia. The fistula closed within three weeks.

CASE VIII.—Mr. H., policeman, aged thirty-seven years, suffered two years with periodic attacks of biliary colic, slight icterus, great itching of the skin accompanying each attack. Operation was performed April 2, 1896. The gall-bladder was found distended with small calculi (1407). Cholecystostomy; uncomplicated recovery; fistula closed within four weeks.

CASE IX.—Mrs. B., aged thirty-two years, married, enjoyed good health until three years ago. She had had repeated attacks of colic attended with jaundice, and had been treated for congestion of the liver. Eight months prior to the time I saw her she had been seized with a very severe attack of colic, with rapid and profound jaundice, which latter, with emaciation, has continued. Operation was performed, August 22, 1895. The gall-bladder was small, and did not contain calculi, nor were there any in the cystic duct. A single large stone was found embedded in the common duct near the duodenum, around which adhesions were numerous. After freeing the duct it was incised and the calculus removed. The incision was sutured first by fine catgut, and over this a continuous Lembert suture of silk was inserted. It seemed secure. A drain of gauze was carried from the suture-point to the lower angle of the wound. The time occupied in performing the operation was fifty minutes; reaction was very good. On the second day, the patient, a very self-willed woman, arose during the momentary absence of the nurse and crossed the room to where a pitcher of water had been left; she helped herself to this and returned to bed. The following night the dressing showed a bloody discharge of almost tarry consistency. The lower stitches were cut, and a large quantity of dark clotted blood removed from beneath



the parietal peritoneum, but no definite point of bleeding ascertained. Liberal drainage was provided. The bloody oozing continued until death ensued from exhaustion at the end of the fourth day. No autopsy.<sup>1</sup>

CASE X.—Mrs. K., age thirty years, married, presented a history of many attacks of biliary colic during the previous four years. Last attack had been very severe in character. Operation was performed February 7, 1896. Cholecystotomy; removal of twenty-six calculi of various sizes. Easy convalescence; fistula did not close until the end of six months.

CASE XI.—Mrs. H., aged fifty-eight years, presented a history of much pain and soreness in the right hypochondrium during the previous five years. She recently had had some fever, but never jaundice; a large tumor in the region of the gall-bladder was easily detected. At the operation, February 14, 1896, the gall-bladder was found to contain a pint of pus and between sixty and seventy gall-stones. Cholecystotomy; bile discharged through the fistula on the second day; easy recovery; fistula closed five weeks after the operation.

CASE XII.—Mrs. S., aged thirty-three years, married, presented a tumor in region of the gall-bladder as large as a fetal head; little pain; never had had jaundice. Operation was performed May 25, 1896, and the gall-bladder was emptied of a quart of clear mucus and probably four hundred calculi, most or which were impacted in the cystic duct. Bile appeared through the fistula on evening of the first day after the operation; quick recovery; fistula closed within eighteen days.

The following case is, I believe, unique in the history of gall-stone operations:

CASE XIII.—Mrs. R., aged thirty-nine years, presented herself for treatment during April, 1896. She was much emaciated and was confined to her bed most of the time. She suffered great pain and tenderness in the region of the liver. She gave a history of having had pains in this region during several years, but the present illness dated back four months, at which time she had a chill, followed by fever, the latter being more or less continuous ever since. Examination revealed the presence of a large mass continuous with the liver and reaching as low down as the umbilicus. Careful palpation led me to believe that the enlargement was the liver.

Exploration, April 6, 1896. On opening the peritoneum the liver was found to be as low as the umbilicus, the abnormal position being the result of displacement rather than any increase in size. Attached to the inferior border of the right lobe of this organ, across its entire length, was the transverse colon.

Beneath the liver was one inextricable mass bound down by omental, colonic, and duodenal adhesions. The mass was undoubtedly inflammatory, and, from the history of the case, I was satisfied that it contained pus. So great were the adhesions to the transverse colon that the liver was drawn down almost from beneath the ribs. The condition impressed me as probably being an abscess of the under surface of the liver. I did not think it wise to attempt a separation of the visceral adhesions which would contaminate the abdominal cavity with pus in a situation which it is impossible to drain satisfactorily. The superior (now anterior) surface of the liver was free and in no way adherent to the parietal peritoneum. I thrust an aspirator-needle through the lower border of the liver to a depth of three inches, and was rewarded by finding pus. The peritoneum was carefully packed with gauze around a space of liver surface two inches in diameter, the center corresponding to the aspiration-point. An incision one inch long was made into the liver, and deepened until the abscess was opened by means of forceps. Six or eight ounces of pus was evacuated, and the cavity of the abscess thoroughly washed through the opening in the liver. The soiled gauze was now removed and replaced by a coronet of fresh gauze, and a large rubber drain carried to the bottom of the abscess cavity. The upper part of the wound was closed by sutures. The patient made an uninterrupted recovery, the temperature falling almost immediately to the normal. The gauze dam was removed on the third day, and the abscess-cavity, which secreted surprisingly little, was irrigated daily.

The seventh day after the operation, after removing the sutures, I concluded to replace the rubber tube with a small strip of gauze, as there seemed so little discharge. In carrying the gauze through the liver into the abscess-cavity my probe came in contact with a hard substance, the click of which was unmistakably that of a calculus. Believing the liver adhesion to the anterior abdominal wall to be firm, I had the patient etherized, enlarged the tract with my finger, and delivered by means of urinary stone-forceps an enormous calculus nearly two inches in its longest diameter. The drainage-tube was replaced; bile appeared through the fistula four days later, the fistula closing on the twenty-third day after the primary operation. The patient made a rapid and complete recovery.<sup>1</sup>

CASE XIV.—Woman, aged forty-seven years, presented a history of many attacks of biliary colic, accompanied with jaundice. There was some tumefaction over the region of the gall-bladder. Operation was performed November 6, 1896. The right kidney was found displaced and adherent to the under-surface of the gall-bladder. Thirty-six stones were removed. Recovery ensued.

<sup>1</sup> I have assisted at two operations upon patients with common-duct obstruction, but without the marked cholemia of long standing which characterized this case, and the same method of suture and gauze drainage had been employed with perfect success. The operations were performed by my associate, Dr. James S. Chenoweth. It is significant that this unfortunate woman should have passed many stones, and lose her life from arrest, and common-duct impaction of the last one in her collection.

<sup>1</sup> This is the only case that I am aware of in which a gall-stone has been removed through the liver. Had I known the true condition at the primary operation it might not have terminated so favorably for my patient. Had this woman lived without operation, I have every reason to believe that the stone would have been discharged into the colon.

# COLLES' FRACTURE AND THE ROENTGEN-RAYS<sup>1</sup>

By CARL BECK, M.D.,

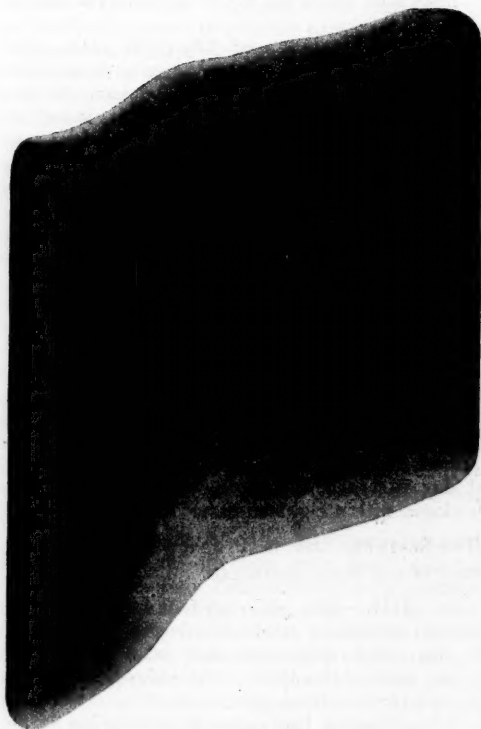
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COLLES' fracture is the commonest of all fractures, yet in regard to no other is there more difference of opinion as to treatment. Since the Röntgen-rays began their triumphant march from the modest town on the Main throughout the world, our knowledge of fractures and dislocations has been greatly enlarged, and our methods of treatment revolutionized. It may be safely said that treatises on this subject which were written before the Röntgen era have ceased to be regarded as authoritative. Following the new discovery great interest was at once concentrated on the much disputed classic fracture of the lower end of the radius, and it soon became evident that a much greater variety of the different types of this fracture (which represents ten per cent. of all fractures) exists than was ever anticipated before. As far as my own experience is concerned, I must admit that I never saw a case in which the diagnosis made

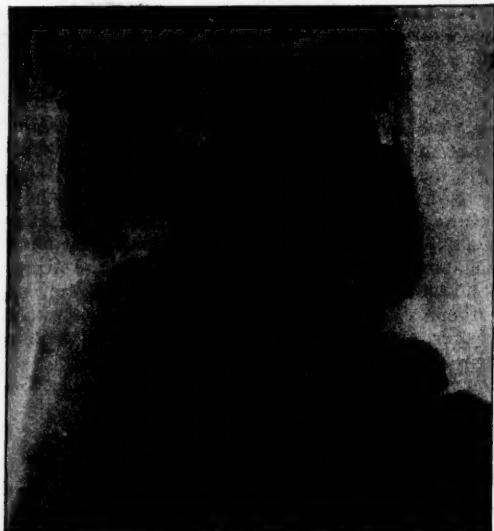
not thoroughly anticipated when examined by the usual methods. One most surprising feature was that in nineteen of these cases a *distinct transverse fissure above the capitulum ulnæ* existed, without causing any apparent symptoms. In seven cases the styloid process of the ulna was entirely broken off. In some instances besides the typical transverse fracture there was also a vertical fracture of the radius,

FIG. 2.



Fracture of left radius.

FIG. 1.



Colles' fracture with slight sideward displacement.

before a skiagram was taken was not more or less modified thereafter, especially when considerable effusion and swelling were present.

Since March, 1896, I have observed forty-four cases of Colles' fracture, all of which were skia-graphed. Most of the skiagrams revealed conditions

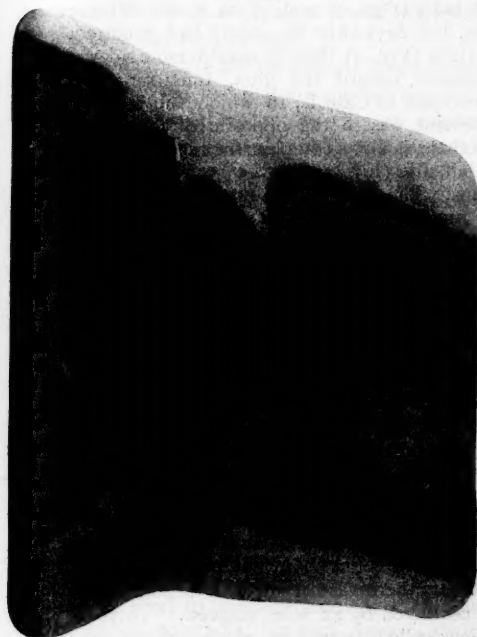
which reached into the radiocarpal joint. In fourteen cases there was no displacement in spite of the great extent of the lesion, the periosteum of the dorsal surface apparently having kept the fragments together.

The clearer our knowledge of a pathologic condition is the simpler and easier will be the indications of treatment. Surely there is a different plan to be pursued if there be a total separation of the lower end of the radius or only a fissure with little or no diastasis. It is of great importance to know the direction of the line of fracture and whether it extends into the joint. Another point which must be considered is whether or not there is any impaction. Sometimes there is a decided turning of the fractured end, its upper margin being forced toward the ulna

<sup>1</sup> Read at a meeting of the physicians of the German Poliklinik, October 29, 1897.

while the lateral margin protrudes and the joint-surface is directed upward to the dorsum. It is apparent that in all such cases unless thorough reduction is at once made the function of the wrist will never be restored; and *vice versa*, if the fracture-line extends upward from the volar side and downward to the dorsum, the displacement must occur in

FIG. 3.



Fracture of right radius.

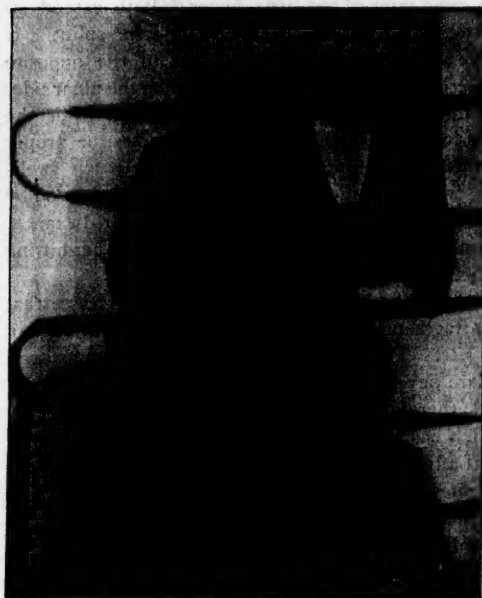
the opposite manner, the principle of reduction, however, remaining the same. If the direction of the fracture-line is oblique it generally extends into the joint—a point which has to be especially considered in the after-treatment. The method of reduction as well as of applying the dressing will also be modified when there is a fracture of the ulna or of its styloid process, or when a bone particle has been chipped off, as shown in Fig. 2. These lesions are often diagnosed with difficulty by ordinary methods, even when the manipulations are skilled, and are seldom recognized by any other means than by the Röntgen rays; but if the nature of the injury can be clearly studied on the photographic plate, the proper line of treatment is easily determined and may always be followed without subjecting the patient to unnecessary or tentative manipulations.

In the treatment of all fractures there are two very simple rules to be observed: (1) Replace a displaced fragment to its normal position, and (2) keep it there. If the skiagram does not show displacement there

is, of course, no need of reduction. This explains why the results in certain cases of Colles' fracture are always good, no matter what sort of treatment is employed. In fact, if treated by a quack, whose ignorance leads him to treat the injury as a sprain with an ointment, poultice, or with "faith," often a better result is obtained in such ordinary cases than by the learned medical neophyte, who, after having made a most erudite diagnosis, immobilizes the joint for too long a period in his zeal to keep the fragments together; there will be no deformity, but adhesions will be formed, and the wrist will remain stiff or immobile. In such a case a patient, the motion of whose hand was not prevented by immobilization, would escape serious consequences. In all cases in which displacement is present of course a great amount of care and deliberation is necessary.

The first requirement, accurate reduction, may be carried out with little difficulty. If forced extension and downward pressure by the surgeon's thumb,

FIG. 4.



Colles' fracture with copious callous formation.

while counter-extension is used on the forearm, flexed rectangularly, should fail, anesthesia must be employed. But the more difficult thing is to keep the fragments well adjusted in a proper position. This I have always been able to secure by applying a long adaptable wire splint (Fig. 4) reaching at the flexor side of the arm from the tip of the fingers to the elbow, the splint being applied while forced



traction is made. If the direction of the displacement is upward—*displacement à la fourchette*, a pad of adhesive plaster is attached to the dorsal integument above the fragment. Then a short narrow splint of wood is placed on the dorsal aspect of the arm, reaching from the metacarpo-phalangeal joint to four inches above the wrist, and is kept pressing down by the application of a gauze bandage. If the tendency of the displacement is downward the same procedure is carried out in the opposite manner, the wire splint being applied on the dorsal and the wooden splint and pad on the palmar side of the arm.

If the displacement be sideways, which is generally the case when there is a simultaneous injury of the ulna, the immobilization must be carried out on entirely different lines. The adhesive-plaster pad must then be applied laterally to the fragment, two long, narrow, wooden splints being used at the same time. One of these splints, being a little broader than the diameter of the bone, begins at the metacarpo-phalangeal joint of the thumb and the other at the same joint of the little finger. Both extend up to the elbow, the same as the long wire splint. If there should be any displacement to the opposite direction, the pad must be applied on the ulnar side. No dorsal splint is used in this variety. After the dressing is finished, the skiagram verifies the proper position of the fragments. If there be much swelling, wet applications may be advantageously used by pouring a solution of acetate of lead, for instance, upon the gauze bandage, the wire splint permitting penetration of the fluid.

It is of the greatest importance in such cases that the fragments, after being properly reduced, be kept *in situ*. The extremely strong ligamentum carpi volare never breaks, as Nélaton well demonstrated, and, therefore, it is in the first instance the bone which has to be taken care of.

If after the lapse of a week agglutination of the fragments is obtained and no deformity is evident, then the soft tissues must receive consideration. It is only then that short splints are in order. They consist of well-padded pieces of wood, extending from the metacarpo-phalangeal joint up to the middle of the forearm. After another week they extend only to the wrist, thus permitting free motion of the hand. The patient is told to move his fingers, as in playing the piano. After the third week massage treatment is indicated, active as well as passive motion of the joint being employed at the same time.

If all these points are observed, and if their proper execution is certified by the skiagram, surgical clinics will no longer furnish so much testimony of deformities and functional impairment following Colles' fracture.

To illustrate some of the points alluded to, the following cases may be of interest:

CASE I.—In this case is shown (Fig. 1) a Colles' fracture with slight sideward displacement in a man, twenty years of age, three hours after the injury was sustained. The small splinters of bone, penetrating the soft tissues, are clearly evident. There is also a distinct fracture-line in the ulna.

CASE II.—In this instance is shown a fracture of both radii (Figs. 2 and 3) in a lad of seventeen years, five days after the injury had occurred. On the right (Fig. 3) there is considerable sideward displacement toward the ulna, thus representing a counterpart to Case I., in which the sideward displacement was in the opposite direction. In this case there is also a complete fracture of the ulna. On the left side (Fig. 2) may be seen two radial fragments. The larger one is not displaced, its fracture-line running into the joint. The small fragment is entirely severed and touches the inner surface of the ulna, which is broken transversely at its lower end. Four very small bone-splinters, piercing the soft tissues, can also be clearly recognized. Five days after the injury the patient was presented to an audience of about one hundred physicians, none of them being able to recognize an ulnar fracture, which, indeed, was hardly to be suspected, as the patient could not only walk about without a splint, but also did light work at the time, and was able to lift heavy objects from the floor. There was hardly any swelling and no visible deformity.

CASE III.—In this is shown (Fig. 4) a Colles' fracture, after two weeks, in a woman forty years of age. There is but slight deformity. On the day of the injury there was considerable displacement, which was corrected by an able surgeon. There is some copious callous formation, which induced the patient to believe that the "fracture was not set properly." The skiagram convinced her that she had been correctly treated.

Nothing may inculpate or exculpate a surgeon more than a good skiagram. In the May issue of the *International Medical Magazine* I published an illustration which showed an enormous amount of callous; it prevented pronation as well as supination so much that the case was pronounced to be one of vicious union. It was only the skiagram that exonerated the attending surgeon.

### MIDWIVES.<sup>1</sup>

By HENRY J. GARRIGUES, M.D.,  
OF NEW YORK;

CONSULTING OBSTETRIC SURGEON TO THE MATERNITY HOSPITAL;  
VISITING GYNÉCOLOGIST TO ST. MARK'S HOSPITAL, ETC.

DURING 1884 a bill was introduced in the State Legislature the aim of which was to grant a charter to a certain college of midwives in this city. After a heated discussion in the County Medical Society a resolution was passed in opposition to the enactment

<sup>1</sup> Read before the Section on Obstetrics and Gynecology of the New York Academy of Medicine, January 27, 1898.

of the bill referred to. Dr. Albert W. Warden and I were sent to Albany as delegates to confer with persons of influence in the matter, and the bill was eventually killed.

So far as I know, nothing has been done since that time to regulate the practice of midwifery in this city, but of late the question has been brought up in the Society of Medical Jurisprudence, and the hope was expressed that adequate legislation might be secured "to regulate the practice of midwifery by midwives in our Empire State."

In this State there are no general laws concerning midwives, and but two that are special, one for Erie County, and the other for the City of Rochester. The one for Erie County, in which is situated the City of Buffalo, was passed on May 22, 1885, and forms Chapter 320 of the laws of the State of New York for that year.

It prescribes that the county judge shall appoint a board of examiners in midwifery, to consist of five members who shall have been licensed to practice physic and surgery in this State. They shall on the first Tuesday of October and April of each year, and on such other days as said board may appoint, examine candidates of the age of twenty-one years or upward, possessed of good moral character, who shall present themselves to be examined for license to practise midwifery in the County of Erie; and shall, on receipt of \$10, issue a certificate to any person so examined who shall be found by them to be properly qualified. The money received shall be applied to defray the expenses of the board.

The successful candidates are entitled, within the County of Erie, to practice midwifery in normal labors, and in no others; but such persons shall not in any case of labor use instruments of any kind, nor assist in labor by any artificial, forcible, or mechanical means, nor perform any version, nor attempt to remove adherent placenta, nor administer, prescribe, advise, or employ any poisonous or dangerous drug, herb, or medicine, nor attempt the treatment of disease, except when the attendance of a physician cannot be speedily procured, and in such cases such person shall at once and in the most speedy way procure the attendance of a physician. The board shall have power to recommend to the Judge of Erie County the revocation of a license, and said judge shall have power to revoke the same.

Any person who shall practise midwifery, or without the attendance of a physician when one can be procured, attend a case of labor within the County of Erie, without being duly authorized so to do under existing laws of this State, or without having received and recorded the certificate named above, and any person who shall violate any of the provisions of this act, shall be fined not less than \$50 or more than \$100, and shall forfeit any certificate theretofore granted under the provisions of this act.

The act regulating the practice of midwifery by others than legally authorized physicians in the City

of Rochester forms Chapter 842 of the laws of the State of New York for 1895, and is, with slight modifications, a verbatim copy of the Erie County act. In Syracuse some time ago the local Board of Health passed a resolution compelling all midwives to register with the Clerk of Vital Statistics, but the County Clerk writes me that he does not think the city ordinance has been lived up to.

In regard to our own city, there is no law whatever regulating the practice of midwifery. The only restriction of any sort is contained in Section 5 of the Sanitary Code of the Board of Health, which requires midwives, as well as physicians, to register in the office of the Register. No qualifications whatever are or can be demanded of any person registering in that office as a midwife. Under the law, or absence of law, any person may practise midwifery.

There are at least five schools of midwifery in this city in which instruction is given and diplomas are issued.

This condition of things is certainly astounding in a civilized country at the end of the Nineteenth Century. Still, if the remedy is to be any kind of official recognition of midwives, and the establishment of one or more legally chartered colleges for midwives, or the appointment of examining boards with the right to grant certificates entitling the candidates to practise midwifery, then I prefer the present chaos, for the simple reason that it cannot last forever, and that it must lead to the enactment of a law by which midwifery, as all other branches of medical practice, is exclusively placed in the hands of the medical profession, where it belongs.

The conduct of labor used to be, and among uncivilized people still is, the exclusive domain of women. Originally any woman who had herself borne children assisted her friends during this ordeal, but in the course of time special authorized guilds of midwives were formed who alone possessed the right to practise the art, and who only called in a physician when they found themselves incapable of completing the delivery.

It was in the beginning of the Seventeenth Century that in Paris doctors first began to assume the direction of normal labor cases. As early as the year 1600 Charles Guillemeau and Honoré began to be in great request by most ladies of quality. Louyse Bourgeois deploras, of course, the immodesty and wantonness of the women of her day, which led them to prefer male physicians, even in ordinary labor.<sup>1</sup>

In England physicians were not employed in normal labors before the end of the last century, and

<sup>1</sup> Wm. Goodell: "A Sketch of the Life of Louyse Bourgeois," pp. 40-41. Philadelphia, 1876.

at first the so-called men-midwives met with great opposition. In Germany the old system obtained much longer, and to a great extent still exists, but it has become quite usual for well-to-do women to employ physicians instead of midwives. In Denmark, also, some years ago physicians began to be employed as accoucheurs.

The reason of this gradual domination of the field of midwifery by physicians is that the superiority of the new over the old system at once becomes manifest wherever it is tried.

I do not share the view of Louyse Bourgeois, who, with jealous eyes saw the advent of those dangerous competitors, and pretended it was only the wantonness of the coquettes that made them prefer the assistance of a physician to that of a midwife. Quite the contrary, many modest women have to conquer their natural aversion to the exposure of their person to the sight and touch of a male practitioner of midwifery, but they do so because experience has proved beyond contradiction the superiority of the physician over the midwife.

Of the thousands of midwives who have practised their art only four have given expression to their experience in printed books, three in France and one in Germany:

The oldest work is that of the above-mentioned Louyse Bourgeois (1609), but that of Charles Guillemeau bears the same date. Justine Siegemundin published her "*Königliche und Churbrandenburgsche Wehemutter*" in 1690. Mme. Boivin dedicated her work in 1811 to Mme. Lachapelle, whose pupil she styles herself. In 1821 the latter published the first volume of her treatise on "*The Art of Accouchement*," the last two volumes of which were edited by her nephew, Antoine Dugès, Professor of Obstetrics at Montpellier.

Great as the experience and dexterity of these women may have been, the science and art of obstetrics is not a structure of their rearing, but of physicians, from Hippocrates down to the present time.

Obstetric work presents certain peculiarities which make it preeminently objectionable to tolerate its performance by half-taught or entirely ignorant persons. While in other branches of the healing art every case concerns the well-being or restoration to health of one human being, in obstetrics every case involves the fate of at least two individuals. Beside the specific services rendered by the obstetrician, at least three other specialties—internal medicine, surgery, and pediatrics—are more or less constantly involved. In no other department does prevention of evil play a similar rôle. For instance, a cross-presentation recognized before rupture of the membranes may be easily corrected by external ver-

sion, and thus the necessity for difficult and dangerous operations at a later stage be averted. Very often the demand for immediate action is imperative, so that no time is left for examining books or consulting men of larger experience.

In no branch of the medical art has the inauguration of antiseptic measures wrought greater reduction in mortality. The records of the New York Maternity Hospital, from 1875 to 1883, show an average maternal mortality of 4.17 per cent., in some years running up to between six and seven per cent. During the last six months of this period it was eight per cent., and during the last month of the era referred to, even twenty per cent. After I had introduced strict antiseptics in that institution, the total mortality from 1884 to 1896 sank to 0.83 per cent., or less than one-fifth of what it formerly was.

So essential is antiseptic practice in obstetrics that, without much exaggeration, we may say that the term aseptic midwifery is synonymous with good midwifery, and likewise, septic midwifery with bad midwifery, no amount of personal skill being able in this department to counterbalance the risks connected with neglect of antiseptic precautions. In an apparently simple case the gravest operation may become necessary, and the choice of methods and results depend, first of all, on the aseptic condition of the genital tract.

In private practice the mortality is twice as large as in maternity hospitals, and, although we unfortunately cannot entirely exempt physicians from blame, this sad result is largely due to the employment of midwives. Even in European countries, with their strong governmental supervision, constant complaints are being uttered in regard to the inefficiency and short-comings of midwives. The average midwife is entirely incapable of foreseeing complications; and preach to her as much as you like, she will never grasp, still less carry out, the principles of antiseptics.

To take, as an example, one of the most common occurrences, a laceration of the perineum; if it is not of unusual dimensions the midwife may not be able to see it at all; or, if she observes the injury, she does not realize its importance, and it is to her advantage to conceal it. Thus, the patient is exposed to an infection which may cost her her life, or she may leave her bed possessing the germ of tedious gynecologic disease, while the honest physician will take proper measures to repair the injury, so that the woman regains her health and strength.

Children suffer still more from bad midwifery than their mothers. While still-births in Berlin occur in three per cent. of confinements, they reach nearly eight per cent. in New York. In New Jersey blind-



ness due to ophthalmia neonatorum has increased five times more rapidly than the population.

Midwives not only do harm through their lack of obstetric knowledge, but they are most inveterate quacks. They treat, first of all, disturbances during the puerperium, later gynecologic diseases, then diseases of children, and are finally consulted in regard to almost everything. They never acknowledge their ignorance, and are always willing to give some advice. They administer potent drugs, such as ergot and opium. Their scarcely veiled advertisements in the newspapers show them to be willing abortionists; and since they have the right to give certificates of still-birth, who knows whether or not an infant's death is a natural one?

Although an evil, midwives are, however, in most countries a necessity, in view of the fact that physicians would be unable to find time to do the work. Not so here, where there is a superabundance of medical men. According to the last census the population of the United States on June 1, 1890, was 62,979,766; or, leaving out Alaska and the Indian Territory, 62,622,250. Of these 30,554,370 were females, only 15,742,636 of whom were of a child-bearing age (between fifteen and forty-nine years of age). At the same time there were 104,805 physicians and surgeons, which gives one physician for every 150 women of a child-bearing age; but women do not bear children every year; quite the contrary. We may estimate, even by a liberal calculation, that in America they, on an average, only give birth to four children in all; consequently, the number of women in the child-bearing period (thirty years) must be divided by about eight in order to find the average number of births *per annum*, which gives about nineteen confinements every year for each physician in the United States.

In the State of New York the total population was 5,997,853, of which 3,020,960 were females. Taking the proportion for the United States, this leaves 1,555,190 women of child-bearing age. Now, there were 11,139 physicians and surgeons, or 1 physician for every 139 women of child-bearing age, or an average of 17 births *per annum* in the State of New York.

In this city, that is the old New York as it existed when the last census was taken, the number of births becomes proportionally smaller. The total population was 1,515,301. Of these 767,722 were females, and by computation it is found that of these 395,556 were of a child-bearing age. As to physicians, the number of male physicians was 3206; that of the females is not specified, but the "Medical Directory" for 1897 shows that in that year there were 145, which gives a total of 3351 physicians and surgeons.

Consequently there was one physician for every 118 women in the child-bearing age, or an average of but fifteen confinements yearly for each physician practising in the City of New York. Nobody will contend that physicians cannot easily attend to this number of confinements.<sup>1</sup>

Analogies cannot be drawn from European countries. New York has proportionally to the population nearly twice as many physicians as London, and the United States nearly three times as many as Great Britain. On the continent of Europe there are still fewer doctors, varying from about 1 in 2000 to 1 in 6,000 of the population.

Even the prejudice of those who object to the male accoucheur, can to a great extent be conciliated, as nowhere is there such a number of female physicians and nowhere better trained nurses than in this country. According to the above statistics there were in the United States 4557, in the State of New York, 693, and in the City of New York, 145 female physicians.

Another objection to the exclusive employment of physicians in confinements has been raised on financial grounds. Midwives, as a rule, charge a small fee, and some physicians a very large one for obstetric work, but with the great number of idle physicians, a woman can obtain the services of many a reputable practitioner during her confinement for the same price she pays to the midwife. And if she is too poor to pay even that modest sum, she can, at least in this city, with the greatest facility obtain gratuitous aid, either in a hospital or in her own home, as she may prefer. Of all medical charities none is so overdone as this. I am myself at the head of a department in a dispensary which sends an experienced accoucheur to the patient's home, and furnishes gratuitously all necessary materials, drugs, and medicines, and still only an insignificant number of women avail themselves of this privilege—freely advertised by means of a placard conspicuously placed in the dispensary referred to. What better proof can be offered that this form of charity is already much overdone?

Even in the country the physicians are able to attend to *all* labor cases, and, even if a woman cannot secure medical aid during her confinement, she is much better off when left alone or assisted by a friend than when provided with the services of a midwife.

Under these circumstances there might occasionally occur a tear of the perineum or a post-partum hemorrhage which might have been avoided by timely obstetric aid, but this danger is so small com-

<sup>1</sup> The State of Nebraska has set a good example by restricting all obstetric practice to those who have the degree, Doctor of Medicine.

pared with that of infection that it may be left out of consideration.

The institution of midwives is a remnant of barbaric times, a blot on our civilization, which ought to be wiped out as soon as possible. Since they have never been recognized by the State, except in a few minor instances, the attainment of such an object ought not to be difficult; but since they have been tolerated it would be necessary for the Legislature to enact a law declaring that only licensed physicians shall have the right to practise obstetrics.

The Legislature would not be justified in an endeavor to prevent one woman from assisting another in childbirth, any more than it would be in an effort to prevent one from advising the other to take a foot-bath, or to put a mustard plaster on her chest; but it certainly has the right to prevent a person from exposing a sign as a midwife and practising midwifery for a consideration. It would probably be necessary to respect the so called "vested rights" of those who at the time of the passage of the new law had been, by legal authority, engaged in the practice of midwifery.

It would be eminently proper for the Section of Gynecology and Obstetrics of this Academy to declare itself in favor of a bill restricting obstetric practice, after a certain date, to legally authorized practitioners of medicine; and it would be desirable to have such a bill indorsed by the Academy of Medicine, and by other societies.

If such a law cannot at present be obtained, it is better to leave the question of midwives as it is. Any law embodying a recognition of midwives and the establishment of colleges for their instruction would not only be injurious to the lawful and rational rights of the medical profession, but would result in great danger to the community at large. It would lead to a considerable increase in the number of midwives, while there would be unsurmountable difficulties in the way of legal supervision of them. If a demand for a law, such as the one I propose, be not acceded to by the legislators, the time is not far, when, nevertheless, it will surely be enacted, and any recognition or organization of midwives will only retard this happy hour, when our hopes in this matter will be realized.

As America has led the world in establishing colleges for the education of women physicians, let it also form the vanguard in a war of extermination against the pestiferous remnant of pre-antiseptic days, midwives, and schools of midwifery.

In accordance with the principle herein laid down I offer the following resolution, which I hope may receive favorable consideration from the Academy:

#### RESOLUTION.<sup>1</sup>

WHEREAS, midwifery, or obstetrics, is an important branch of medical science and art;

WHEREAS, midwives are not recognized by the State;

WHEREAS, Section 153 of the Laws of New York, 1893, Chapter 661, amended in 1895, prescribes penalties for any person who, without being then lawfully authorized to practise medicine within this State and so registered according to law . . . shall assume or advertise any title which shall show, or tend to show, that the person assuming or advertising the same is a practitioner of any of the branches of medicine;

WHEREAS, midwives by their ignorance and lack of cleanliness do great harm to parturient and lying-in women, and assume to administer potent drugs to them without the advice of a physician, and often treat sick women and children, and frequently are guilty of causing abortions.

*Resolved*, That the Section on Obstetrics and Gynecology strongly recommends the taking of immediate steps to secure the passage of a law providing for the supervision of all persons, not legally qualified physicians, now engaged in practising midwifery, and debarring from such practice all persons not proven to be competent and qualified; and also containing such provisions as, without conflicting with existing rights, shall tend to confine the practice of midwifery to qualified medical practitioners.

### CLINICAL MEMORANDA.

#### A CASE OF FEVER WITH INTERCURRENT PLEUROPNEUMONIA.<sup>2</sup>

BY PALMER C. COLE, M.D.,  
OF NEW YORK.

DURING June of last year I was called to see H. G., male, aged thirty-two years. I reached his bedside at 12.30 A.M., and found him delirious and in a high fever; temperature, 104.5 F.; pulse, 120. There was constant vomiting, and his conjunctiva was a deep yellow. Up to a few hours before he had been in apparent good health, coming home in the evening at 9 P.M. after a hard day's work, eating a hearty supper, and about 10 P.M. he commenced to feel ill. At 11 P.M. he had a chill, and took 10 grains of quinin, a hypodermic injection of about 1½ grains of morphin, and went to bed. Vomiting and delirium followed, in which condition I found him.

Subsequent investigation disclosed the fact that he was addicted to the use of morphin, taking about a grain hypodermically every twenty-four hours, as he afterward stated. Judging from symptoms, I concluded that the case was one of acute bilious fever complicated with malaria. I prescribed calomel, soda, and sugar of milk (10 grains of each), to be followed by a seidlitz powder within a few hours if the bowels did not move. The cal-

<sup>1</sup> Passed by the Section on Obstetrics and Gynecology of the New York Academy of Medicine, January 27, 1898.

<sup>2</sup> Read at a meeting of the Northwestern Medical and Surgical Society of New York, December 15, 1897.

omel and soda checked the vomiting, and the seidlitz powder was followed by five copious bilious evacuations. I now gave full doses of quinin, but observing no benefit from the administration of this drug, the dose was reduced the next day to 2 grains three times daily. I also slightly reduced his allowance of morphin, and, as the heart was weak, ordered strychnia sulph. gr. 1/60, and tr. digitalis, 1 minim, three times daily, to be taken alternately every four hours.

There was no improvement, and as I considered his condition critical Dr. Janeway was asked to see him in consultation. He was out of town, and the family called another physician who saw the patient without my knowledge, and who left me written advice to administer 10 grains of phenacetin every four hours, and also wrote that he would meet me the next day. The phenacetin was tried, with injurious results, causing emesis and loss of appetite. It was discontinued after the third dose and previous treatment resumed. The physician referred to was two hours and a half late in keeping his appointment, and in consequence I never met him.

On the morning of the fifth day incipient pneumonia of the left lung was detected. With this complication in a case in which the illness was already critical and the condition steadily growing more grave (pulse, 140; temperature, 104.6° F., respiration rapid, and a weak heart in spite of tonics and stimulants), I made up my mind there was but one hope, which lay in the application of the cold pack.

Having come to this conclusion, I sent for Dr. Simon Baruch.<sup>1</sup> Dr. Baruch was unable to meet me before 10 P.M., when examination showed that there was slight pleuritic effusion on the left side. Dr. Baruch advised the administration of 10 grains of calomel, which was at once given, and then the application of cold compresses was commenced under Dr. Baruch's personal supervision. The temperature of the water used was 65° F., and the compresses were renewed every hour. The cold pack in this case consisted of two heavy linen towels (without fringe, which is important) loosely stitched together and covered with white flannel. On removal the linen was thrown into a large tub of water kept at a temperature of 65° F., and the flannel was dried. The compresses extended from the neck to just below the base of the lungs.

In renewing compresses it is important that the patient *be not* raised in bed, but gently rolled over, a fresh compress taking the place of the one removed, and the patient gently rolled back. In addition to the application of the pack, the patient was sponged with cold water once or twice a day. Dr. Baruch met me the next morning, and, finding no improvement in the symptoms and no diminution of temperature, suggested the advisability of changing the packs every forty-five minutes. Though this was done, there was no improvement, but by evening the right lung was also invaded—without any increase of the affected area in the left, in which the condition seemed to remain stationary. The next morning, as the tempera-

ture and pulse were slowly climbing up, I ordered the cold compresses to be applied every half hour, but after about eight hours concluded such frequent changes were not beneficial, and returned to applications every forty-five minutes. This was continued for about eight days, by which time the temperature had fallen to 101° F.; respiration and heart-action decidedly improved, and then the cold compresses were stopped. Convalescence from this time on was slow but uneventful.

Morphin had been entirely withdrawn by the end of the second week, strychnin and digitalis taking its place, and when the patient finally resumed his work he was a well man. He had no recollection of what had occurred during a period of four weeks. He subsequently thanked me more for having cured him of his opium habit than for saving his life. I have not the slightest doubt that the patient owed his life to the persistent external use of cold water, and that under any other treatment he would have died.

**RETROPHARYNGEAL ABSCESS ULCERATING  
INTO THE LEFT INTERNAL CAROTID  
ARTERY (?) FOLLOWED BY RIGHT-  
SIDED HEMIPLEGIA WITH  
APHASIA AND RE-  
COVERY.**

BY MELVIN M. FRANKLIN, M.D.,  
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SURGEON TO CHARITY HOSPITAL, AND TO THE OUT-PATIENT DE-  
PARTMENT OF ST. JOSEPH'S HOSPITAL.

THIS case is reported because of its rather unique complications, the happy subsidence of ominous symptoms, and because of the extreme rarity with which such an affection is followed by restoration of health.

A. S., aged seven years, was first seen May 11, 1896. Upon examination it was found that the patient was suffering from a simple angina with very little tendency to any of the subjective symptoms of the affection; there was, however, a slight edema of the posterior wall of the pharynx. A gargle was prescribed, and it was ordered that the child be kept quiet. The next day I was hurriedly summoned, and found the patient in a state of collapse, with blood flowing from the nose and mouth. The child was stimulated with strychnia and atropin and the fluid extract of ergot was injected subcutaneously. Closer examination revealed a pulsating swelling on the left side of the neck. Ice and pressure were applied, and, as a coagulum had formed in the nose and the hemorrhage from the mouth had largely ceased (which might probably be explained by syncope), instead of looking immediately for the cause of the hemorrhage a pint of saline infusion was administered subcutaneously. After this the child's head was gently raised and the mouth opened, when blood was seen gushing from a point posterior to the left tonsillar pillar. With the view of applying pressure internally a soft catheter was introduced through the anterior, and brought out of the posterior nares, and a large piece of sponge was pulled tightly into the vault of the pharynx. The stimulants previously given now began to have some effect, and were continued at proper inter-

<sup>1</sup> Twenty-five years ago I used cold sheets in typhoid fever, but had it not been for Dr. Baruch's invaluable papers and discussions on hydrotherapy, I should not have thought of applying this treatment in pneumonia.



vals, so that in the course of a couple of hours the child was in a fairly good condition. At four o'clock the same afternoon the patient was again visited, and the general condition found about the same, but aphasia, together with paralysis of the right side of the face and the right arm, was becoming marked. The paralysis rapidly developed until by six o'clock there was complete loss of sensibility and paralysis of the entire right side of the body, and also complete aphasia. The following morning the condition was much the same, with the exception of an increase in the pulse and a temperature of 101° F. For three days the general condition remained stationary, though the tumor in the side of the neck gradually disappeared. At the end of this time the nasal plugs were removed, after which there was some slight hemorrhage, but this was readily controlled by the use of local hemostatics. In the course of a month the child was able to be about, but could not walk unaided. Several months elapsed, however, before articulation was properly performed. At the present time (a year later) the patient has completely recovered the power of speech and suffers only from a slight disability in the use of the right arm and a talipes equinovarus, the latter being relieved by the use of proper apparatus.

As to the question from which artery the hemorrhage occurred, it is only necessary to glance at the subsequent symptoms to confirm the diagnosis of ulceration into the left internal carotid artery; for, explained in any other way, the case becomes a most remarkable pathologic coincidence. There is already in literature the report of a similar case which, unfortunately, terminated fatally. That the hemorrhage, in my case, should cease spontaneously seems highly improbable, although the nervous phenomena which followed point directly toward the establishment of the diagnosis named. It may be said that other causes than the one already suggested could have produced the hemiplegia, but why should two such unique morbid changes occur practically simultaneously, each bearing directly on the other, and yet so widely different in character? The condition might, again, have been caused by the marked ischemia resulting from the hemorrhage. Whether or not the paralysis was embolic in nature or due to cortical hemorrhage or thrombus, the chief causes of cerebral paralysis, it is difficult to determine, but without a previous constitutional diathesis it is most likely, in a child, to have been caused by an embolus of the middle cerebral artery—a terminal branch of the internal carotid.

## SPECIAL ARTICLE.

### THE LAPORTE CASE DUPLICATED IN WEST VIRGINIA.

By T. A. HARRIS, M.D.,  
OF PARKERSBURG, W. VA.

ON the 16th day of January, 1895, Dr. A. S. Keever of Belleville, accompanied by Dr. W. S. Keever of Parkersburg, called upon me at my house. Dr. A. S. Keever asked me to go down to the lower end of the County to operate upon a Mrs. Tice for ovarian tumor. The plan

was to go to Belleville the next morning, from which point we were to go to Mr. Tice's house, eight miles from Belleville. Mrs. Tice was a patient of a Dr. Deem (of Tyner, Wood County, W. Va.). Dr. A. S. Keever stated to me at this time that he had seen Mrs. Tice the previous day (the 15th) in consultation with Dr. Deem, and that she had an ovarian tumor which Dr. Deem had previously tapped twice, but failed to empty the sac, as the fluid was too thick to run through the cannula. The little fluid that came away was of a dark, grumous character, and the small quantity removed did not make any impression upon the size of the woman's abdomen. He stated that there was no probability that pregnancy could be a complication, for, while he had made but little examination to determine this point, Dr. Deem had said that he had made a thorough examination and had repeatedly passed a sound into the uterus. They had agreed that she was suffering from blood poisoning and could live but a short time unless an operation was performed for the removal of the tumor.

I objected to going to the woman's house to operate, and stated that I thought the operation would be much more likely to succeed if the woman were first removed to Parkersburg, or even to Belleville. He said it was impossible to move her in her present condition, and he thought I would realize this when I saw her. He stated that it was a condition of emergency, and that if something was not at once done for her she would die, and that soon. I objected to doing the operation in this way, as I had but little expectation of its success, but as a matter of humanity I agreed that Dr. William Keever and I would go down the next morning and do the best we could for her. On the 17th, Dr. Keever and myself went down to Belleville, where we were joined by Dr. A. S. Keever: we rode eight miles up hill and down, over frozen roads and snow, to Mr. Tice's house. We found a small house with one fair-sized living-room, and one or two small rooms adjoining. In the living-room we found Mrs. Tice sitting in a chair; in the room was a bed and a stove. We expected to have met Dr. Deem there, but he had not yet arrived. I sat down by Mrs. Tice (the family were all strangers to me), made some superficial examination, and talked to her about her condition. She told me that the dropsy had been coming on during five or six months; that she had had a lump in her left side. She said that she was not able to lie down to sleep, but had sat in her chair during the last six weeks. The pulse was weak and frequent; temperature about 103° F. She had had chills; the skin was cool and moist; she presented the appearance and symptoms of one suffering not only from the presence of an abdominal tumor, which interfered with respiration, heart's action, and the functions of stomach and bowels, but also of a person suffering from toxemia, the source of which I took to be the tumor which had been tapped, but not emptied, and which was then, and had been for some time, leaking into the abdominal cavity from the hole made in it by the trocar. I told her that I thought we could relieve her of her trouble, but at the same time I explained to her the dangers and uncertainty of the operation which she would have to undergo. She said she wanted to be relieved of her present distressing condition,

for she said she could not live as she was. She was willing and desirous that the operation be performed.

Dr. Deem not having arrived, we concluded to make all the necessary arrangements for the operation. By the time they could be completed we expected he would be on hand, as a messenger had been sent to his house, only a short distance away. We procured a table, and arranged it; the necessary vessels were provided, containing the antiseptics for the instruments and for the cleansing of the hands, etc.; also, towels soaked in antiseptic solutions. Mrs. Tice was placed upon the table for the purpose of a careful examination, and this without any anesthetic; the fact that an ovarian cyst filled the entire abdominal cavity was easily established; there was the mark of the trocar between the pubis and the umbilicus. The breasts were rather large and flabby, the areolæ being darkened in color and having numerous papillæ. Upon passing a finger into the vagina the os uteri was found sufficiently open to admit two fingers, and it projected between the labia so as to be plainly seen without the aid of either speculum or tenaculum. Presenting from within the uterus, just within the dilated os was the head of a dead fetus. At this time Dr. Deem arrived, and he was told of the condition of affairs, and was asked to make an examination, which he did. Then assisted by Dr. Wm. Keever, I proceeded to extract the dead fetus. The mouth of the womb was just within the external genitals, forced down by the pressure of the tumor above, and the efforts of Nature to expel the dead fetus.

In removing the fetus I introduced my fingers into the uterus, after making digital dilation, and with a small pair of forceps caught one foot and brought it down and out. In doing this the body was rotated within the uterus. Making some traction on this leg it came away at the hip-joint. The second leg came off in the same way. An arm, when drawn upon, parted at the elbow. It was plainly evident that the fetus was in a state of decomposition. Securing the pelvis of the fetus with a tenaculum, it was extracted, and the head retained within the uterus. I felt sure that with very slight traction the neck would part, and the head be left loose within the womb. I tried first the tenaculum, but this tore through the skull as it would through a piece of wet paper. I then asked for a blunt hook. Dr. A. S. Keever handed me a piece of ordinary wire slightly hooked at one end, which had been polished with a file and washed in an antiseptic solution. Guiding this wire with my finger, I thrust it into the skull which was just within the mouth of the womb, and extracted the head, the brain oozing out of the opening made by the tenaculum. The entire decomposing fetus had been extracted piecemeal. The cord was limp and flaccid, resembling a piece of tape; it easily parted from the fetus. The placenta was still adherent to the uterus, and was retained. No special effort was made to remove it for fear of hemorrhage from the flaccid uterus. I felt sure that coincident with the occurrence of uterine contractions the placenta would be expelled in the natural way, and also that I could not remove it at this time without the employment of more force than I felt was justifiable under the circumstances. During these procedures

the woman laid upon the table without any anesthetic. She made little or no complaint of pain, and then only when I was dilating the mouth of the womb with my fingers.

Having cleansed everything connected with this part of the operation, we made a careful examination and found the woman in as good condition for the removal of the tumor as she was before the extraction of the dead fetus. As said before, up to this time, anesthesia had not been induced, as very little pain was complained of during the previous manipulations; the patient had not lost two ounces of blood, and was in full possession of all her faculties. It was decided to proceed with the operation for the removal of the ovarian tumor. Dr. A. S. Keever administered the anesthetic, while Dr. Wm. Keever prepared the surface of the body for operation, which he did with all antiseptic precautions, scrubbing the surface thoroughly with soap and water, shaving it with a razor, and then scrubbing it again with a solution of bichlorid of mercury, and finally applying towels wrung out in a solution of bichlorid. Everything now being ready, Dr. Wm. Keever and myself prepared ourselves by most thoroughly disinfecting our hands and arms. I took my place on one side of the table, Dr. Wm. Keever, as assistant, being on the other side, with Dr. Deem behind him to act in the capacity of general utility. Before the operation was begun Dr. Deem passed the catheter and drew off the urine.

Upon inspection of the abdomen it presented the appearance of a woman at about the eighth month of pregnancy. At a point about midway between the pubis and the umbilicus was seen the site of the puncture where tapping had been performed by Dr. Deem; the skin puncture had entirely healed. Making, then, an incision about five inches long between the navel and the pubis, the tense skin retracted and the tumor was disclosed, bearing upon its anterior surface the open puncture of the trocar from which the cyst contents were slowly oozing. As there was already an opening in the tumor I did not think it necessary to try to empty it with a trocar at this stage; the opening in the abdominal wall was not long enough to allow so large a tumor to pass through it. The patient was brought near the edge of the table, and I seized the tumor with a pair of forceps at the point of puncture so as to close the opening. She was turned over on her side, nearly on her face, on the edge of the table. The tumor was then punctured with a bistoury, and its contents poured out into a bucket held by her father, assisted by Dr. Deem.

The cyst was multicular and contained several smaller cysts within the large outer sac; these were successively punctured and emptied. When the tumor had been sufficiently emptied to allow it to be drawn out through the abdominal incision it was found to have no adhesion except a small pedicle connecting it with the left ovary. This pedicle was securely tied with a heavy silk ligature, and dropped back into the abdominal cavity. There being no adhesions, there was no weeping into the cavity. In the pelvis there was a small amount of what appeared to be leakage from the tumor, not more than a spoonful

or two, which was carefully sponged out. The abdominal wound was sutured, dressed, and secured by a bandage, no drainage being provided. The woman was placed in bed, hot applications made to her body, and she gradually recovered from the influence of the anesthetic.

We remained in the house in all two or three hours. Before leaving I had quite a talk with the patient. She had entirely regained consciousness, and was not nauseated. She wanted to know if the tumor had been removed, how large it was, and asked various questions relating to herself. Her pulse and general condition were fairly good under the circumstances; temperature elevated, and skin warm. She expressed herself as being comfortable, and said it was a great relief to be able to lie down, and also that she "had some place to breathe now," respiration being much embarrassed previous to the operation. I parted with her expressing my hope and expectation that she would soon be well. She was left in charge of Drs. A. S. Keever and Deem. She was seen by them the next day, at which time, the placenta having become detached, it was removed and the uterus washed out with a disinfecting solution. She was at that time much in the same condition as before the operation; slightly weaker, and at times slightly delirious. Their prognosis was grave. She died before they met to see her the following day.

The case presents several points of unusual interest, the principal one being the unfavorable condition of the patient previous to operation; she was suffering from the well-marked symptoms of sepsis of such degree as would indicate an early fatal termination. She had been tapped for an ovarian cyst, which had not been emptied of its thick, dark, grumous contents, but was leaking into the abdominal cavity; whence, after undergoing decomposition, this material was absorbed into the general system, producing the blood-poisoning. She was at the same time carrying in her womb a dead and decomposing fetus of about four months. All the complications made a very unfavorable prognosis in an operation performed in a remote country house with few of the necessary comforts, and where she must be left to the nursing of well-meaning but ignorant relatives. It emphasizes the oft repeated advice, "Never tap an ovarian cyst unless you are prepared to operate for its removal." The presence of a dead fetus or a decomposing fetus is not often a complication of this operation. A notable thing, also, is the fact that the continual oozing of the fluid from a puncture of an unemptied cyst will prevent the adhesion of the cyst to the abdominal wall at the point of puncture.

But there is a point connected with this case of far greater interest to the medical profession in the State of West Virginia than anything furnished by its medical aspect. This case has been made the basis of a suit for malpractice against Drs. T. A. Harris, W. S. Keever, and A. S. Keever, and the damages laid at \$10,000. The charge stripped of its verbiage is as follows: (1) That the fetus removed was alive; (2) that the mouth of the womb was cut open with a knife; (3) that

the fetus was pulled out piecemeal and killed with a piece of rusty, unclean wire, which had been a piece of fencing wire; (4) that the placenta should have been removed at once; (5) that the operation for the removal of the ovarian tumor should not have been done at once, but some (an indefinite) time should have been allowed to elapse between the two (alleged capital) operations; (6) that in emptying the ovarian tumor of its contents a trocar should have been used, and it should not have been punctured with a knife; (7) that in puncturing it with a knife its contents were allowed to flow into the abdominal cavity; (8) that the abdominal cavity was not washed out with any chemic antiseptic.

These several charges were solemnly sworn to either by Dr. Deem or by Mr. Scott (the father of the woman) or by a Mrs. Canary (a relation of Mr. Scott's). When it was proposed to put on the witness stand the doctors concerned in the operation it was objected to by the prosecution, and an article was found in the Code of West Virginia which says, "that when one party to a suit is dead the other party shall not testify as to any communications or transactions had with the dead party." The learned judge in this case ruled that the term "transactions" applied to this case; that a surgical operation is a transaction; that the defense could not testify in their own behalf; could not give in detail the conversation which took place in Parkersburg, and which led to the operation; that Dr. A. S. Keever could not testify as to the conversation at his consultation with Dr. Deem two days before the operation, nor as to his examination of the patient at that time, nor as to his diagnosis made at that time; that neither Dr. Harris nor Dr. W. S. Keever could testify to what they said, saw, did, or thought within the room at the time of the operation upon Mrs. Tice, nor was Dr. A. S. Keever allowed to testify as to Mrs. Tice's condition the day after the operation, when he saw her for the last time, nor to testify to any conversation with Dr. Deem at that time. And it was further ruled among other things by the learned judge above referred to that no question should be put to any expert witness that was not based on the assumption that the evidence sworn to by the prosecution was true. The only persons present at the operation besides the doctors were the father of the woman, the grandmother, the husband, and a relative. Dr. Deem swore to certain of these charges as given above, Mr. Scott and Mrs. Canary swore to certain others; the grandmother was not produced as she was said to be out of the State. The husband did not testify as he is administrator of the estate of the deceased, and brought the suit. It was said that if he had testified the defendants might have been heard.

After the trial had continued ten days the jury disagreed, two being for the defense and ten for the prosecution. The case will, of course, be tried over again.

The comments I wish to make are as follows: No physician is safe in practising in West Virginia, if he loses a patient; it matters not whether the case be medical, surgical, or obstetric; if he is sued on the civil side of the court he will not be allowed to testify in his own behalf. If he is fortunate enough to be sued for a criminal act he



may testify; no evidence of skill, ability, or experience will avail him, for the court holds that "The greater the ability and the more the experience the greater the responsibility." No legal process can be drawn that will relieve doctors from responsibility. The only help is to take disinterested witnesses to all surgical operations and cases of labor, or cases of serious illness, or to trust to the next Legislature to amend the law, or to give a different construction of the word "transactions" in the law referred to.

NOTE.—This case was again called for trial at the ensuing November term of the court. At that time the judge who had presided at the original trial was dead, and not one of the original attorneys in the case appeared for the plaintiff. He was represented by the stenographer of the original trial, and he pleaded that "he was unprepared for the trial and had not a witness present." The case was thrown out of court. During the session of the Legislature of 1897 the law was so amended as to allow physicians to testify in their own behalf. This same law, just as it was in West Virginia before being amended, is in the codes of a number of other States—notably in New York—a menace to all practitioners of medicine and surgery.

## MEDICAL PROGRESS.

*Rupture of the Callus in Fracture of the Patella.*—BEGOUIN and AUDERODIAS (*Gaz. méd. de Paris*, October 23, 1897) have collected some of the published reports of fractured patellæ treated by the method advocated by Tilanus, viz., by massage and early movements. They find that of thirty patients so treated, no less than seven suffered the accident of refracture through the callous. This percentage is so high that it must be taken into account in deciding on the best method of treatment of this condition. The two procedures which are to-day attracting the attention of surgeons are the methods of Tilanus, and the osseous suture. In point of view of rapidity of cure the former must give place to the latter; and when to this disadvantage is added the refracture of the callous in almost every fourth case treated by massage and early motion, the suture must be regarded as the method of choice.

*A New Radical Operation for Inguinal Hernia.*—BERNHARD (*Correspondenz-Bl. f. Schweiz. Aertzte*, November 1, 1897) advocates a new operation for the radical cure of inguinal hernia. The departure from previous operations consists in the separation of the testicle with its cord, the ablation of the tunica vaginalis, and the return of the organs in question to within the abdominal cavity, outside of the peritoneum. When this is accomplished, the accurate closure of the inguinal canal is comparatively a simple task. Bernhard has performed this operation upon two patients, each time with success. He has, of course, no means of knowing what the fate of the transplanted testicle may be. As a disadvantage of this method is mentioned the difficulty of diagnosis in case of a subsequent development in the transplanted testicle of such diseases as attack this organ, for instance, syphilis, tuberculosis, carcinoma, sarcoma, cysts, etc. A

warning is given to those who perform this and other hernia operations to avoid, if possible, dividing the skin of the scrotum, as the probability of primary union is thereby much diminished.

*Formula for Home Modification of Milk.*—WESCOTT (*Archiv. of Pediat.*, January, 1898) is of the opinion that mixtures of cream and whole milk are more reliable and accurate than mixtures of cream and under-milk. He suggests the following simple and practicable formula:

Cream (12 per cent.)	-	7 ounces, 2 drams
Whole milk	-	8 ounces, 1 dram
Lime water	-	2 ounces
Sugar of milk (dry)	-	1½ ounces
Water	-	22 ounces, 5 drams.

This formula will give forty ounces of a mixture containing three per cent. of fat, six per cent. of sugar, and 1.5 per cent. of proteid. The advantage of a formula of this sort is that the fat and proteid may be gradually increased or diminished without frequent changing of the whole formula. To do this it is simply necessary to alter the amount of milk and cream in the mixture. Thus, in normal cases, a half ounce of milk may be added, that is, a teaspoonful more each day for four days in the week, this quantity to be maintained for the balance of the week. Then, if digestion is not disturbed the same increase may be directed for the next succeeding week, or possibly it may be necessary to omit the increase for a week—according to the condition of the child.

*Disinfection of Houses with Formaldehyd.*—JOHNSON (*Brit. Med. Jour.*, December 25, 1897) has obtained good results in disinfection of rooms by formaldehyd, liberating the gas under pressure from a mixture of equal parts of formalin, and twenty per cent. calcium chlorid solution. He has found formaldehyd lamps unsatisfactory. He also found it necessary to use larger quantities of formaldehyd than are generally advised, the best results being obtained upon using one pound of formaldehyd per 1000 cubic feet to be disinfected. At a cost of from twenty-five to thirty cents per pound the expense of disinfecting in this manner is not great for private houses. He made a number of experiments to determine the penetration of the gas in absolutely tight chambers, and in those having ordinary cracks. As a result, he has found it more serviceable to generate an excess of the vapor rather than to paste up cracks, though no large crevices or drafts should be permitted. For smaller articles the use of a portable chamber made of "enameled duck" having a projecting flap around the open end so as to be rolled up, with a corresponding flap of the cover, gave him good results.

*On the Duration of Life of Epithelial Grafts.*—WENTSCHER (*Centralbl. für Chir.*, January 8, 1898) has conducted experiments to determine the length of life of epithelial grafts outside the body. He preserved the grafts either in normal salt solutions, or dry, in sterilized gauze. Later, these grafts were transplanted upon suitable surfaces (usually prepared by excision), such as granulating ulcers of the leg. The oldest graft which grew was twenty-two days old. Grafts which had been preserved

dry for four weeks showed no evidences of growth after transplantation. Cold had very little effect upon them. It was found that grafts which had been kept frozen for fourteen hours, when thawed and placed upon a suitable surface grew without difficulty. Heat was more disastrous, a temperature of 50° C. (122° F.) in one case prevented the subsequent growth of a graft. Grafts are very easily affected by chemic influences. Even weak antiseptic solutions prevented their subsequent growth in every case, with one exception.

**Soap as a Disinfectant.**—TALBOT (*Dietet. and Hygien. Gaz.*, January, 1898) reviews the work of various experimenters and shows that soft soap in one-per-cent. solution is a valuable disinfectant for bacillus anthracis, cholera germs, for the bacteria of typhoid fever, and also for bacterium coli. Care, however, should be taken in the choice of potash soaps. The ordinary soft soap of commerce is often extremely unclean and possesses very little value. It is necessary to use a strong solution, and to wash the hands thoroughly with plenty of soap and water. Unfortunately, soap has no effect upon pus cocci. Almond soap was found to be more powerful than other varieties experimented with. It was also shown that soap containing antiseptics, *viz.*: benzol, carbolic acid, has less antiseptic power than the same amount of these substances without the soap. Therefore, the practice of manufacturing soaps with the addition of disinfectants is not founded on rational principles. The proper method of disinfecting the hands must still continue to be, first, washing them with soap, and afterward with the selected disinfectant.

**Purulent Inflammation of the Fat Capsule of the Kidney.**—MAASS (*Centrabl. f. d. Grenzgebiete d. Med. und Chir.*, December, 1897) draws some interesting conclusions from twenty-two cases of purulent inflammation of the fat capsule of the kidney. In all of these the perinephritic abscess was secondary to suppuration elsewhere. The source was usually in the kidney itself, although sometimes it was in an inflammation of the connective tissue of the pelvis. Such abscesses may also be secondary to inflammation in the thorax. The clinical symptoms are those of abscesses in general: fever, localized pain, pressure upon the colon, etc. The diagnosis is, in most instances, easy to make, especially if a tumor has formed in the lumbar region, or if edema of the skin presages the approach of pus; but in the very beginning of the trouble the diagnosis may be most difficult, even impossible. Treatment consists in evacuation of the pus by means of the most convenient incision. This is usually found to be an oblique one, beginning in the angle between the twelfth rib and the quadratus lumborum muscle and extending downward and forward a distance of seven or eight inches. The prognosis after operation is good. Sixteen of twenty-one patients treated by this method recovered.

**Chronic Proctitis.**—TALLEY (*Mathews' Quar. Jour. of Rect. and Gastro-Intes. Dis.*, January, 1898) regrets that chronic proctitis has not yet received the study and attention which its importance demands. He insists that the only proper method of making a diagnosis of a rectal affection is by means of direct inspection. The use of

Kelly's proctoscope, with a strong reflected light, will clear up many obscure cases. This instrument is better than a speculum and is less painful. In examination with a proctoscope the mucous membrane closes uniformly over the open end of the instrument as it is withdrawn. The patient may be placed in the lithotomy or knee-chest position, the latter being preferred when high examinations are to be made. Gonorrheal proctitis is common in prostitutes, the discharge from the vagina easily infecting the rectum, but is not found in men unless they practise pederasty. Non-specific chronic proctitis may occur as an acute inflammation, as a superficial ulceration, as a papillomatous vegetation, or it may involve the sub-mucous tissue, causing proliferative stenosing proctitis. The main symptom of this former variety is slight tenesmus, with frequent mucopurulent stools, at times streaked with blood. The patient should be put to bed, and placed upon a bland diet. The sphincter muscle should be divulsed, and the ulcerated mucous membrane touched with a strong solution of nitrate of silver. The rectum should be irrigated daily with warm boric-acid solution. Injections of sweet oil and iodoform, and the introduction of suppositories of iodoform and boric acid are also grateful to the patient.

Proliferative stenosing proctitis never heals of itself. It may be treated palliatively by means of dilatation with rubber bougies, passed at intervals, though not oftener than every five days. If the stricture is very resistant an internal proctotomy should be performed to facilitate dilatation. This is an operation practically without danger when the stricture is not more than two inches above the external sphincter muscle. After division of the stricture division of the rectum should be performed, and elastic bougies should be passed from time to time to avoid recurrence of the stenosis.

**Recent Observations upon Cocain Poisoning.**—GRIFFIN (*Phil. Med. Jour.*, January 8, 1898) calls attention to the variety of susceptibility and idiosyncrasy to cocain which different individuals present. Some patients who are acutely poisoned exhibit maniac excitement, while others are stupid. It is well known that poisoning has followed the use of a dose far short of the maximum therapeutic allowance, even .077 of a grain having caused serious symptoms. There are also instances in which a solution of a certain strength has been used without unpleasant effects, while a repetition of the same dose on a subsequent occasion has caused toxic symptoms. The injection of camphor dissolved in ether and the employment of artificial respiration have recently been extolled as the best treatment for the acute poisoning.

In chronic poisoning by cocain there is one symptom known as Magnan's sign, which is of considerable importance in establishing a diagnosis when the use of the drug is denied, and is also of importance in other cases as indicating to the physician the necessity for immediate discontinuance of the remedy. This sign is a hallucination of sensation, the patient complaining of feeling some foreign body beneath the skin. This is generally described as being small in size, and is usually ascribed to the presence of "sand," "worms," or "microbes."

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## THE NEW YORK CITY BOARD OF HEALTH AND THE BRUSH BILL.

IN last week's issue we had occasion, in connection with the bill before the Legislature restricting the powers and acts of the Board of Health of New York City, to comment in general upon the excellence of the work of this board and the credit it had reflected upon the community and the country. One feature of the bill, that bearing upon the management of pulmonary tuberculosis, was treated in detail. Judging from the notices in the secular press and in some contemporary medical journals, there apparently exists such a shadowy notion in regard to the provisions of the Brush Bill that it seems wise to present more in detail the main features of this measure.

1. The clause in the former bill restricting the presidency of the Board of Health to a layman is stricken out, thus opening the possibility of that office being occupied by a member of the medical profession, although the health-officer of the port is debarred from holding the position. This provision seems eminently wise. There is no reason why the president of the board should not at times be a physician.

2. The board is reduced to five members, con-

sisting of the health-officer of the port and four commissioners appointed by the mayor, two of whom shall be physicians. The president of the police board, who was formerly a member, is thus excluded. This provision is of little moment, and is as unnecessary of discussion as it was of insertion in the bill.

3. The term of service is changed from six to four years. This brings the tenure of office in correspondence with that of the mayor, and so savors more of politics than of statesmanship.

4. The clause empowering the board to produce diphtheria antitoxin or other antitoxins is stricken out, and all authority to relieve, by antitoxin treatment, persons suffering from diphtheria or other infectious disease is omitted, as well as the power of disinfection in these diseases. The cunning hand of some ardent opponent of antitoxin seems to be apparent here. As we read the revised bill, no authority to produce, to use, or to distribute antitoxin is given the board. Indeed, all detailed reference to diphtheria is stricken from the law, the disease simply being mentioned as one of the infectious, contagious, or pestilential diseases. What more startling announcement could come thundering in the ears of an intelligent community, to say nothing of those interested in and conversant with sanitary measures, than that there has been taken away from the sanitary authorities and the medical profession in conjunction therewith, the power and the privilege of reducing the death-rate of diphtheria in New York City from 35.2 per cent. during the four years preceding 1895 (when antitoxin was first employed) to 16.3 per cent. for the three years following that period, and to 14.6 per cent. during the year 1897? The medical profession of the city has come to rely so implicitly upon the diphtheria antitoxin of the Board of Health that during the past year 1100 cases of diphtheria were treated without charge by the Board of Health at the request of the attending physicians. These patients were reported by the physician in charge as being too poor to pay for his visits.

5. The power to afford gratuitous vaccination to and among the poor is retained, and the board is empowered "to procure and preserve pure vaccine lymph or virus." No authority is given to produce vaccine lymph, and yet, as shown in our editorial of last week, the Board of Health, by experimentation in its laboratories during the year 1896, brought



vaccine lymph to a higher standard of perfection than was previously known.

With all due consideration of the economic principle that subsidized institutions should not be allowed to compete with private enterprise, and with all respect to the private commercial drug-houses who supply the profession and the community with other high-grade pharmaceutical preparations, we would submit the proposition that in an enterprise involving so much scientific experimental work and in which so much is at stake, involving an almost complete revolution in the principle of therapeutics, an exception can justly be made. We trust, however, that the time is not far distant when the art of producing biologic products will have reached such a definite, settled basis as will permit commercial competition to be a sufficient motive, not only to maintain but to advance the excellence of these preparations. It is to be hoped also that when that time arrives sufficient public funds will be placed at the disposal of the Board of Health to enable it to carry on its laboratories without the necessity of selling any of its products. By private letters received from the H. K. Mulford Company and from Parke, Davis & Company assuring us that they are now producing the most highly concentrated product that has ever been offered to the medical profession, the realization of hopes in the direction referred to seems already at hand.

6. Every physician is obliged to report every birth occurring in this city at which he may be present under the penalty of a fine of \$100. This is an apparent injustice. Physicians are frequently called to poor women for the purpose of correcting some malposition in obstetrics, for which they receive no remuneration whatever, and yet they are obliged to be at the expense and trouble of reporting such births or be fined \$100. In England a fee of \$1 is allowed for every birth reported.

7. On the same penalty for omission, physicians are required to report all cases of infectious, contagious, or pestilential disease within twenty-four hours after the nature of the disease is ascertained or suspected. The following diseases are named as being embraced in this classification: Measles, diphtheria, scarlet fever, smallpox, chickenpox, typhoid fever, typhus, cerebrospinal meningitis, Asiatic cholera, and yellow fever. Evidently the intent of

this clause was to exclude pulmonary tuberculosis, but, in doing so, as was pointed out in these columns last week, a number of well-recognized infectious and contagious diseases have been omitted.

Several other minor changes have been made in the wording of the bill, but the provisions already mentioned are the principal ones requiring attention. With the exception of the clause first named, they all show ill-considered preparation and in their entirety so restrict the sphere of action of the health authorities as to menace the welfare and health of the community. The bill should be withdrawn.

#### WHAT'S IN A NAME?

It is a phrase often quoted that the rose by any other name would smell as sweet, and this saying not only has the advantage of being ancient but likewise truthful. Many persons interested in the development of a health service in this country have expressed a well-meaning and undoubtedly honest objection to the name of the Marine Hospital Service as indicative of a service caring for the public health.

It is true that the name Marine Hospital Service does not indicate specifically all the functions which this department performs. It was baptized 100 years ago by our respected forefathers, and that they did not have the gift of foresight and prophecy is not extraordinary. It is not always that christening produces results which entirely suits later conditions of life. A child may be baptized Napoleon Bonaparte Smith, and turn out to be a character more befitting the name of Peter Cooper Smith. The fact that he was christened Napoleon Bonaparte does not necessarily mean that he is expected to pass through the world performing the same sort of volcanic upheavals as his namesake, but it none the less cripples him in the performance of duties to which he is by training and instinct better fitted. The growth and development of the Marine Hospital Service in the line of its work as a public health service has been gradual and satisfactory. Were it specifically named The Public Health Service a closer designation of one of its important functions would probably be attained, but that it is not so designated is not an insuperable objection to its continuing in the performance of work which it has satisfactorily accomplished in the past, and is performing with equally good results in the present.

The health interests of Great Britain are under the supervision of the Local Government Board, a title which no one will claim indicates just what its duties are, but there seems to be no demand in England for a change of this title so long as the work is properly performed. The Department of the Interior scarcely describes the variety of work which is continually and satisfactorily being performed under this name. No one seriously undertakes to suggest changing the name of this department of the Government, because the title does not accurately express all its duties. In fact a common instance of misapplication of names is the term "quarantine service" or "quarantine station." This term originally meant a forty-days' detention of ships or persons coming from infected places, a regulation which does not exist at the present day, and has been entirely superseded by modern and intelligent methods of disinfection and control. It would be better to substitute another word for this wherever it occurs, but it has become so fixed in our vocabulary that its eradication would be impracticable.

The Marine Hospital Service is an old organization, and has made its reputation under its present name. The public are so used to it that if it were sailing under another name they would have to become educated to the fact that it was not a new organization that was doing its work. It is known from Maine to California and from the Lakes to the Gulf, as our political orators would say. There is no demand for a change of name, and but for the fact that it has been suggested by interested and well-meaning gentlemen who think it is a serious obstacle to the Service becoming the representative health organization of the country, it seems to us that the objection is unimportant, and has no bearing upon the real question. The Service performs its duties satisfactorily considering the limited powers at present entrusted to it, and so long as it does this there need be no discussion as to the colors under which it sails.

## ECHOES AND NEWS.

**A Medical Senator.**—Dr. Samuel Pozzi, the eminent French gynecologist, has been elected Senator for Dordogne.

**The Registration of Midwives.**—Meetings in support of a bill providing for the registration of midwives are being held in various parts of England.

**Fees in Insanity Cases.**—In Kansas, jurors who serve in cases in which the sanity of an individual is to be determined, do not receive a fee unless they find a verdict of insanity.

**Motor-Cradles.**—The latest scientific addition to the nursery is the motor-cradle. It is a question, however, whether babies should be rocked either by machinery or by hand.

**Typewriters' Cramp.**—According to the *Phonetic Journal* one of its correspondents is suffering from this new form of occupation neurosis as a result of a too assiduous use of the typewriter.

**Appointments at Mt. Sinai.**—At a meeting of the Board of Directors of Mt. Sinai Hospital, New York, held February 13th, Drs. Morris Manges and Nathan E. Brill were appointed Visiting Physicians to the hospital.

**Department of Hydrophobia.**—A department of hydrophobia, similar to the Pasteur Institute in Paris, is to be added to the Institute for Infectious Diseases in Berlin, of which Robert Koch is director.

**Deportations from State Hospitals.**—During the past year the New York State Commission in Lunacy has sent to other States and countries 110 alien and non-resident inmates of the New York State hospitals.

**Individual Drinking-cups.**—The Columbus (Indiana) Health Board has issued an order requiring the pupils of the public schools to provide themselves with individual drinking-cups. The board is also in favor of individual communion services.

**The American Medical Association and Dr. Busey.**—Dr. Samuel C. Busey of Washington, who was appointed to deliver the address on State Medicine before the American Medical Association in Denver, has resigned the appointment on account of ill-health.

**Medical Popes.**—According to the *British Medical Journal*, several of the Roman Pontiffs were students of medicine in their youth, and one, John XXII., who reigned at Avignon from 1316 to 1334, was a qualified doctor according to modern ideas, and wrote medical works.

**Louisiana's New Board of Health.**—Governor Foster recently announced the appointment of the following gentlemen as members of the new State Board of Health: Drs. Edmond Souchon, John J. Castellanos, L. F. Reynaud, Luther Sexton, H. S. Lewis, Messrs. S. O. Thomas, J. W. Castles, J. D. Hill, and J. C. Denis.

**Second Quinquennial Prize.**—The second quinquennial prize of \$1000 dollars will be awarded on January 1, 1900. This prize, under the will of the late Samuel D. Gross, M.D., is to be awarded every five years to the writer of the best original essay upon some subject in surgical pathology or surgical practice founded upon original investigations. The candidates must be American citizens.

**Another Verdict for a Hospital.**—Justice Stover, in the Supreme Court, New York City, recently dismissed a suit brought against the Montefiore Home by Alexander Bursell for \$100,000 damages for the death of his son who was killed by falling through the elevator shaft while a patient at the Home. Justice Stover held that charitable institutions are not responsible for the acts of their employees.

**Tennessee State Board of Health.**—The death of Dr. J. Berrien Lindsley, as formerly announced, left vacant the responsible position of secretary of the State Board of Health, with which organization he had been connected many years. Dr. J. A. Albright, at that time president of the board, we learn, has resigned his office and has been elected to succeed Dr. Lindsley. Dr. Albright has our congratulations and best wishes.

**Unmerited Criticism.**—The *New York Medical Journal* calls attention to the fact that the *Journal de Médecine de Paris* for January 16th states that Mr. Cornelius Vanderbilt has employed Dr. Jean Charcot as his physician for a cruise upon his steam yacht, and remarks that it thinks Dr. Charcot does not do great honor to his father's name by accepting a place as physician and nurse which would be more suitable for an indigent student.

**Opposition to the Dispensary Bill.**—At a conference of representatives of dispensaries of Greater New York recently held, the bill to regulate dispensaries, now in the hands of the Committee on Cities, was opposed as being harmful and unwarranted. A resolution in opposition to the bill was carried by a vote of 41 to 2, the representatives of the Northeastern Dispensary and of the East Side Dispensary, respectively, alone voting in the negative.

**The Brush Bill Condemned by Central Labor Union.**—At a recent meeting of the Central Labor Union of New York, one of the delegates attacked the bill which cripples the work of the New York Board of Health by prohibiting the manufacture and sale of vaccine virus and antitoxin. He characterized the bill as vicious and a direct blow at the praiseworthy and successful efforts of the Board of Health in keeping down the death-rate. A resolution condemning the bill was passed, and it was ordered that a copy of the resolution be sent to each member of the Legislature.

**Dr. Weir Mitchell's Novel.**—According to the *Bookman* Dr. Mitchell's book "Hugh Wynne" is about the second in popularity at the present time. A review has appeared in the *Friend's Intelligencer* of Philadelphia, and also in pamphlet form, the avowed object of which is to correct some of the descriptions given in Dr. Mitchell's book of the manners and customs of the Friends at the time of the Revolution. The resultant of this is a sketch of the old-time Quakerdom of the City of Brotherly Love which might never have been brought out had it not been for the "mistakes" of Dr. Mitchell.

**Obituary.**—Dr. John Cronyn, one of Buffalo's prominent physicians, died there February 11th. Dr. Cronyn was born in Ireland, obtained his degree of M.D. at the

University of Toronto, and settled in Buffalo in 1859. He was an ex-President of the Medical Society of the State of New York.—Dr. George C. Briggs, a prominent Vermont physician, died in his carriage of heart disease, at Burlington, Vt., February 11th. Dr. Briggs was sixty-eight years old, was graduated from the University of Michigan School of Medicine, and for ten years was Professor of Materia Medica in the University of Vermont.

**Kipling's Estimate of American and Other Practitioners.**—Rudyard Kipling, the poet novelist, in an after-dinner speech at a banquet given in London to Sir William Gowers not long since, paid a graceful tribute to the heroism of the medical fraternity. He had mixed with doctors, he said, the world over, and had seen them going to certain death with no hope of reward. He had seen them handling cholera and smallpox, and, when dying therefrom, telegraphing for a substitute. He had seen them, in America, manage a practice twenty miles in each direction, driving horses through eight feet of snow to attend an operation ten miles away, digging their horses out of the snow and then proceeding on their way. Mr. Kipling declared that it was one of the proudest things of his life to have been associated with "real fighting men of this class."

**Charity Abuses in Michigan.**—Recent information from Detroit leads to a belief that an earnest effort will be made there to combat the growing dispensary evil. In this respect, as in many others, New York has set a good example, which we are glad to know is being followed by our brethren throughout the country; though it is to be hoped that they will not injure the prospects of reformatory measures by an internecine strife such as at present characterizes the position of New York physicians on the question of a bill to abolish medical charity abuses—a measure of such vast importance, not only to physicians, but, on a general economic basis, to the people at large. In Michigan the abuse referred to seems especially rife in the free dispensary of the University Hospital at Ann Arbor, and it is against this institution that criticism is particularly leveled.

**The Marine Hospital Service and National Quarantine.**—It is somewhat gratifying, after several months spent by the MEDICAL NEWS in presenting the various aspects of this subject, to note that the *New York Medical Journal* and the *Medical Record* have rallied to the support of the Marine Hospital Service and united with the MEDICAL NEWS in indorsing the Caffery Bill establishing a National Quarantine in charge of that department of government. The quarantine convention recently held at Mobile, Ala., discussed the various phases of quarantine in detail, but failed to pass a resolution indorsing any of the bills now before Congress. Doubtless the discussion in the convention was a source of enlightenment to the various interests represented regarding the necessity of uniformity in law and practice.

**Smallpox in North Carolina.**—This disease has been hovering along the southerly borders of the "Old North State" for several months. It has been said that as many



as thirty Georgian counties have been infected; the disease has also made its appearance at Rock Hill, S. C., but it was not known until quite recently that a case had entered the North State. That case was at last brought into Wilmington, in the person of a colored train-hand, whose "run" took him frequently into South Carolina. The editor of the *Bulletin* of the State Board of Health, Dr. Lewis, sounds a note of warning to the local health authorities that the time has come for each and all of them to proffer free vaccination in their respective precincts. He further remarks that the number of persons in that State who have never been vaccinated at all is so great that he and other sanitarians view the situation with alarm.

*Dr. Kelsey and the Post-Graduate.*—Dr. Charles B. Kelsey of New York recently applied to the Supreme Court of the city for a writ of mandamus directing the Board of Directors of the New York Post-Graduate Medical School and Hospital to reinstate him as professor of surgery in that institution, a position which he held from March, 1890, until January 27, 1898, when he was removed without a hearing by the Board of Directors of the institution. Charges of disloyalty toward the hospital had previously been preferred against him. Dr. Kelsey was removed by a vote of 6 to 1. The by-laws provide that a vote of three-fourths of the board, which numbers eleven, is necessary for a removal, so the question of the legality of the removal rests upon whether this means three-fourths of the whole Board, or three-fourths of those present and voting. Decision was reserved.

## CORRESPONDENCE.

### THE DISPENSARY BILL.

To the Editor of the MEDICAL NEWS.

DEAR SIR: Your allusion in a recent issue of the MEDICAL NEWS to my opposition to the Dispensary Bill seems to call for a reply on my part; indeed, I am glad to have this opportunity to place this bill before the medical profession in its true light.

In the first place, you are mistaken if you think the Chairman of the Legislative Committee of the Medical Society of the State of New York is the only person opposed to the measure under consideration, for my action is endorsed by the whole committee, by the officers of the State Society, and by the majority of the medical men of the State. It is safe to say that not one-fourth of the profession of the city of New York would endorse this bill if its true character were known; I doubt very much if you would. Let me place before you some of our objections to it:

This bill provides that after its passage all dispensaries must make application in writing, accompanied by such statements, verified by oath, as may be necessary, to the State Board of Charities for a license. If this board believes that the operations of said dispensary will be for the public good a license shall be issued; "but that no dispensary shall enter upon the execution, or continue the prosecution of its purpose unless licensed in this way."

The bill gives the State Board of Charities absolute power to make such rules governing dispensaries as it may deem proper, to alter or amend the same at will, and to revoke licenses at pleasure. In other words, it takes away from the medical profession and the Boards of Managers of all dispensaries in the State of New York any voice in the management of these institutions, and vests this power in a State Board, political in its character and subject to change at any time. Now we ask you and we ask the medical profession if this is just? Is this what we have been striving for for several years?

What would be the effect of a law of this kind? Under Chapter 771, Laws of 1895, the State Board of Charities has the right to maintain a general supervision over all institutions of a charitable or eleemosynary character, incorporated or unincorporated, whether State, county, or municipal, and to call upon the Attorney-General of the State, or the district attorney in any county, to enforce its rules; further than this no institution can receive money from the county or State if the State Board of Charities objects. Is this not power enough? With all this power, the State Board of Charities has done little or nothing! If the present dispensary bill should become a law is there any reason to suppose they would do any more? The law would in all probabilities become a dead letter, and the medical profession, instead of being benefited, would be prevented from doing anything further in its effort to remedy dispensary abuses. On the other hand, the State Board of Charities could, on October 1st, close every dispensary in the State of New York. When it comes to dispensaries in drug-stores and tenement-houses, we have little to say. If it is in the interest of the public to close them, we would be willing to assist any effort in that direction, but we will oppose to the end any effort the consequences of which would be to place a weapon so terrible in the hands of any State board. The dispensaries in the State would be in a constant condition of uncertainty, which would seriously cripple their usefulness; trust moneys, instead of being used to benefit the poor, would be diverted to purposes for which they were never intended; *i.e.*, defraying the expenses of endless litigations, and in the end the medical profession would receive the contumely it would deserve if it allowed so pernicious a measure to go unchallenged. The question is naturally asked if there is no way in which this matter can be adjusted, and in answer I beg to refer the members of the Medical Society of the County of New York to the minutes of the meeting of May 24, 1897. It is recorded that over seventy-seven per cent. of institutions of this city expressed their willingness to correct any abuses that might exist in the dispensaries. Let the medical profession of the State, through representatives of the State and county societies, get together and confer with the boards of managers of the various institutions, and with the State Board of Charities if necessary, and there is no doubt a satisfactory solution of this vexed question could be found which would be just to all concerned.

I believe I have said enough to show my position in this matter, but I voice the sentiment of the Legislative

Committee, if referred to, when I say that we feel that we would be false to the trust imposed in us if we did not protest against a bill so manifestly unjust to the medical profession and to the community at large as the present Dispensary Bill.

Very truly yours,

FRANK VAN FLEET,

Chairman of the Committee on Legislation of the Medical Society of the State of New York.

116 EAST EIGHTY-SECOND STREET,  
NEW YORK, February 7, 1898.

#### VIBRATORY THERAPEUTICS.

To the Editor of the MEDICAL NEWS.

DEAR SIR: My attention has been called to a historic article on vibratory therapeutics from the pen of Dr. Frederick Peterson which appeared in a recent issue of the MEDICAL NEWS. Doubtless in the preparation of his article the writer was ignorant of the fact that in the second edition of my work upon nervous diseases (H. C. Lea's Sons, 1881) I described and depicted a vibrator of my invention which I had used since 1879. This, so far as I know, was the first *percuteur* in which electricity has been employed, and is, I believe, to-day the best, because of the fineness of its vibrations. Some years ago I purchased a motor instrument from Gaiffe of Paris, which is more compact than those the Doctor describes, and this, too, he appears not to have seen. After many years use of vibratory therapy I am now convinced that its value is greatly exaggerated, and depends more upon the creation of suggestion than anything else, in which conclusion I think I am supported by Dr. Dana, who has gone fully over the ground. This form of treatment has been so popular with hypochondriacs that a few years ago a company with a large capital was formed here to exploit a "household" vibrator, of which nothing is now heard.

ALLAN McLANE HAMILTON, M.D.,

44 EAST TWENTY-NINTH STREET,  
NEW YORK, December 29, 1898.

#### OUR PHILADELPHIA LETTER.

[From our Special Correspondent.]

THE INVESTIGATION OF HOSPITALISM—CONTAGIOUS DISEASES DURING 1897—THE STATE QUARANTINE—PHILADELPHIA HOSPITAL'S NEW BUILDING—THE DELIVERY OF MILK IN SEALED JARS—LUCIEN MOSS HOME FOR INCURABLES—MASS-MEETING IN FAVOR OF THE FILTRATION BILL.

PHILADELPHIA, February 12, 1898.

IT is difficult to conceive a more complex undertaking than the effort, now in its inception in this city, to eliminate "hospitalism." If undertaken in a spirit of fanaticism directed toward hospital physicians as a class, as seems the inclination of some agitators, the movement must surely stir up such hostility among this class of the medical profession that cooperation will be impossible, and the outcome will be profitless. On the other hand, if undertaken with conservatism and with the help of representative local medical societies, the evil may be rem-

edied to the satisfaction of all. The movers in this pending attempt at reform must necessarily represent all classes of respectable regular physicians—the general practitioner, faculties of the medical schools, and the physicians connected with the various city hospitals. The officers of the Charity Hospital, who are the prime movers in this inquiry into the question of indiscriminate free treatment by hospitals, are inclined to adopt a rational and sensible method of procedure, by inviting the attention of the County Medical Society to their plans, and by asking this body to act with them in the matter. This is to be done at the next meeting of the Society, on February 23d, until which time the precise method of beginning the investigation must remain a matter of conjecture. Meanwhile, the daily press is taking up the matter, and throws open its columns to every one who may choose to express his views, with the result that fictitiously signed letters from holders of medical degrees (?) have begun a tirade against hospital physicians which cannot but reflect unjustly upon the objects of their disapproval; for how is the newspaper-reading public to discriminate in a matter of this sort? Undoubtedly hospital abuses exist, but they should be remedied by the profession itself, and an editorial throttle should be applied to the rantings of the many disgruntled correspondents whose anonymous expressions only retard real progress toward a solution of the difficulty, and help to breed in the minds of an impressionable public a preconceived biased view of the actual situation. Apropos of this topic, it may be remarked that Director Riter, of the Department of Public Safety of this city, has written to Dr. Frederick Holme Wiggin of New York demanding an explanation of a charge that "in some instances policemen are paid \$1 or \$2 for each patient they bring to the hospital," made by Dr. Wiggin in his address on the hospital question at last week's meeting at the Charity Hospital. The outcome of this will be watched with interest, for the charge has caused a sensation in local medical circles and in the police department.

The annual report of Dr. William M. Welch, physician in charge of the Municipal Hospital for Contagious Diseases, shows that during the year 1897 more patients were admitted to the hospital than during any previous year in its history, the number exceeding even the totals of 1871 and 1872, when smallpox was very prevalent here. Dr. Welch attributes this increase not to an extraordinary prevalence of contagious diseases last year, but to the strict enforcement by the health authorities of the law requiring the placarding of infected houses, with the alternative of removal of the infected inmates to the city's hospital, and to the growing popularity of this institution. The increase in the number of admissions to the Municipal Hospital during the last eight years is shown by the following summary: 1890, 52; 1891, 127; 1892, 480; 1893, 524; 1894, 810; 1895, 1191; 1896, 1252; 1897, 2179.

The quarantine officers of this State are protesting against the passage of a bill now before Congress which, should it become a law, would seriously interfere with the power of State quarantines, by allowing a vessel

to enter port with a clean bill of health from the government quarantine officials, regardless of the certificates of the State and local authorities. Inasmuch as the Pennsylvania State Quarantine Service has proved its usefulness in numerous instances in which the government officers have passed vessels requiring a later detention, it does not seem that the passage of this pending bill is quite justified. Philadelphia, at any rate, does not feel that the power of her State and city authorities should be curtailed in such a summary manner.

The Board of Charities are endeavoring to secure for immediate use an appropriation of \$60,000 from Councils to complete the new additions to the insane department of the Philadelphia Hospital. This sum, which, like the filtration bill is delayed by councilmanic inactivity, is urgently needed to provide heating apparatus for the new building, which cannot be occupied until this provision is made. The new building will afford accommodations for 1400 patients, while the present quarters of the insane department, which are intended for but 1050 inmates, actually contain 1340.

Arguments for and against the practice of delivering milk to customers in sealed glass jars, now largely adopted here, took place this week before the Board of Health. The question arose from a petition recently presented to the board by a local dairymen's association, asking for the passage of an ordinance prohibiting the distribution of milk in glass jars, on the ground that this custom tends toward the dissemination of disease. Thus far, the evidence produced by the complainants has not been of a very convincing nature, when opposed to arguments in favor of the glass-jar system by such authorities as Mr. William Gordon of the Walker-Gordon dairies; Dr. J. Cheston Morris, whose dairy-farm in Chester County is considered a model of its kind; Dr. Meade Bolton, of the New Jersey State Laboratory of Hygiene; and Dr. Ravenal, Bacteriologist of the Pennsylvania State Live Stock Sanitary Board. Another hearing will be given the oppositionists at a later date, and the Board of Health promises to make a thorough investigation of the whole matter before delivering an opinion.

The erection of the buildings of the Lucian Moss Home for Incurables of the Jewish Hospital will be commenced within a short time, the present delay being due to the auditing of the accounts of the donor, whose will is still under legal consideration. The Jewish Hospital received last week a gift of \$10,000 to the endowment fund of the institution, in memory of the late Ida M. Fleisher.

That the people of Philadelphia have awakened to the fact that something must be immediately done to provide a pure water-supply was amply and emphatically demonstrated at a mass meeting held at Horticultural Hall, on February 12th, under the auspices of the City Organizations' Committee, for the purpose of forcing Councils, through public opinion, to remedy the trouble by at once passing a bill creating a loan for the establishment of a filtration-plant. Representatives from all classes of citizens were present at this meeting, and definite demands were made that immediate steps be taken to eradicate the present typhoid epidemic by providing a new water-supply

for the city. Members representing the following bodies were present at this popular demonstration: the College of Physicians of Philadelphia, the Philadelphia County Medical Society, the Health Protective Association, the Board of Trade of Philadelphia, the Trades' League, the Civic Club, the New Century Club, the Union Labor League, and many other societies, building associations, and hospitals. Addresses were made by Frank J. Firth, chairman of the committee, by Judge Ashman, by Rabbi Krauskopf, by Dr. S. Solis Cohen, by William Waterall, and by Dr. John K. Mitchell. Resolutions were unanimously adopted for presentation to Councils, urging immediate action for the creation of a loan "for the purification and filtration of the city water-supply, under direct municipal control, ownership, and management, and in no other way." This is the second indication of the popular mind presented to the notice of the city legislators this week. On February 10th, Councils' Committee on Water gave a hearing to the views of representatives of local medical societies and municipal organizations, who joined forces for the occasion, to urge upon Councils the necessity for the installation of a filtration-plant at the earliest possible moment. At this hearing the following organizations were represented: the College of Physicians of Philadelphia, by Drs. John K. Mitchell, A. C. Abbott, and D. D. Stewart; the Philadelphia County Medical Society, by Drs. S. Solis-Cohen, Edward Jackson, and William M. Welch; the Municipal League, by George Burnham, Charles Richardson, Clinton Rogers Woodruff, and Hector McIntosh, and the City Organizations' Filtration Committee, by Frank J. Firth and J. Vaughan Merrick. Views similar to those expressed at the mass meeting at Horticultural Hall were laid before Councils' Committee on this occasion.

### OUR PRAGUE LETTER.

[From our Special Correspondent.]

THE GERMAN UNIVERSITY OPENS ITS DOORS ONCE MORE—THE BOHEMIAN UNIVERSITY AND THE CZECHISH MOVEMENT—INFECTIOUS DISEASES IN PRAGUE—THE STATISTICS OF THE PRAGUE MATERNITY IN THE MIDST OF THE PREVAILING UNSANITARY CONDITIONS.

PRAGUE, February 11, 1898.

THE German University opened its doors once more after a six-weeks' interregnum on January 10th. Peace, at least for the time being, seems to have settled down over Prague, and the two universities, the German and the Bohemian, will continue their sessions side by side as before. It is officially announced that a new Czechish or Bohemian university is to be opened in Mähren (Moravia) before the end of the year. Though founded only in 1881 and the medical department only in 1884, the Bohemian University of Prague has now over 2300 students, of whom about 750 are engaged in the study of medicine. It has this large number not because it has attracted students from the German University, for the number of students at the latter institution has only decreased by about three hundred, but rather because the spirit of advance among the awakening Czechish people



has attracted numbers of students to their university. The intellectual enthusiasm so notable among the other Slav peoples of northeastern Europe has touched the Czechs too, and with surprising results. From the medical faculty of the Bohemian University has come during recent years a series of scientific advances which have attracted worldwide attention.

Professor Hlawa's name is well known in pathologic anatomy, and from Professor Horbaczewski has come some of the most striking work of late years in physiologic chemistry. A series of text-books in Bohemian by the medical professors has served to fix the status of the language and give it a place in the scientific world which it did not have before.

The Bohemians insist that their language shall, equally with German, be the language of their courts of law, of government business, and of the officials who caused the late unpleasantness. The means employed—the riotous demonstration, the injury of the property of German citizens, and of the German University, cannot but be universally decried; the movement itself—a demand of their language rights for the sake of their nationality can scarcely fail to elicit sympathy from all sides. The rioting was the work of the ignorant, the mobile vulgus so hard to control, whom a demagogic press had worked to a frenzy because it seemed as though recent laws enacted in their favor might be declared legally inactive. The Czechish movement itself depends for its vitality upon a widely different class—a thoroughly determined, highly intellectual body of men who will not cease their endeavors until they have acquired for their country the autonomy which Hungary enjoys in the Austrian Empire.

Of this body of educated men and zealous patriots many are physicians who have been the apostles of the movement to the country people. Bohemia possesses a very large number of doctors, many of them young. About five years ago, between the Bohemian University with 1200 medical students and the German University with 800 there were altogether 2000 embryo doctors coming into existence each year. All of them were practically from Bohemia, all intending to practice within her borders, and yet Bohemia is but a small country. It can readily be understood then what a large and influential body of patriots they make. An interesting study in supply and demand is the gradual reduction of the number of medical students at both universities, until now scarcely 1000 are here. The number of law students has almost proportionately increased at both universities.

There is a lesson for the antivaccination agitators in the faces one sees so often on the streets of Prague. Much oftener than elsewhere in central or eastern Europe, at least, one comes across faces deeply pitted with pockmarks. Fifteen to twenty-five and more years ago, in the country districts of Bohemia there was great opposition to the enforcement of the vaccination regulations. This was shared in many cases by the natural leaders of the people, the schoolmasters, the local clergy, and the officeholders. The result was as might have been expected, a series of smallpox epidemics, some of them of very severe types.

Gradually the state of things altered. The spirit of advancement among the Czechs led to the general recognition of the foolhardiness of further refusal to accept what the world has long recognized—the immense benefits of vaccination. Curiously enough, the same reformation of feeling has not occurred among certain of the German rural populations, especially near the Bohemian boundaries, and I am credibly informed that now it is among this class of the population that smallpox continues to be more or less endemic; so it is likely enough that the striking lesson of the pockmarked faces in the streets of Prague will continue for some years to be a warning to those who, for reasons which it is not easy to understand, persist in their senseless opposition to vaccination in countries in which it is to be supposed that civilization is far enough advanced for the public to accept sanitary precautions at the bidding of science, and not oppose them for factitious, imaginary, and sentimental considerations.

Here, in Prague the lesson of the benefit of sanitary and hygienic precautions, from their absence, is extremely striking. All the infectious fevers find a place here at almost any season of the year. Typhoid rages because the water-supply is contaminated, and there are always a large number of patients with this disease under treatment in the hospital. Diphtheria and scarlet fever seem especially common, though the former, thanks to the serum treatment (in most cases they administer absolutely no other remedy), now claims less than one-third the number of victims it formerly did.

Owing to the unsanitary, overcrowded, uncleanly condition of the poorer classes, skin diseases seem to take on a special character. Impetigo is very common, and modifies other skin affections to a considerable extent. Rheumatism seems much more than ordinarily frequent. It takes on a great deal more than usual of the character of an infectious disease, and seems to be at times even directly contagious. Slight epidemics of it seem to have come under observation, and the cases are prone to occur in groups with definite relations to one another as regards time and place. Its analogy with pneumonia in these respects would seem to be much more outspoken here than elsewhere in Europe, though most of these peculiarities have been noticed by other clinicians, for instance, Eichhorst and Senator.

Influenza would seem to be endemic here, and cases are observed in the hospital wards every fall and winter, especially in which the diagnosis is made, not from the clinical symptoms and course of the disease alone, though these are extremely characteristic, but from the demonstration of the bacilli in the sputum. On the whole, the hygienic conditions here are just such as prevailed generally in Europe fifty years ago. Determined, well directed efforts which deserve the highest commendation are being made to change this state of affairs. Medical men head the movement, and the most advanced scientific principles are guiding the endeavor. Within a few years the whole aspect of things will have undergone a radical change for which Prague will be indebted to the medical profession. Meanwhile, Prague remains an *argumentum crucis* for the doubters of the

benefits of modern hygienic and sanitary principles and their practical application.

Notwithstanding this utterly unsanitary condition of the poorer classes, Prague has a maternity hospital which can claim favorable comparison with any like institution in the world. With a mortality of considerably less than one per cent. for all cases received, and a morbidity that is wonderfully small, more than 3000 cases of confinement are conducted a year. The material is freely used for teaching purposes, but with such thoroughly antiseptic and aseptic precautions that in whole services of 300 to 500 cases treatment is carried out with total absence of fever, or, perhaps, fever is present only in such cases as have been treated and examined before being admitted to the hospital. The result is all the more marvelous when compared with the extremely high mortality which prevailed before the advent of modern obstetric methods. Prague, with all her disadvantages, continues to be the teacher of the world in obstetrics, and gives besides the striking lesson of how much may be accomplished, even under the most unfavorable circumstances, in ridding labor of its dangers.

#### TRANSACTIONS OF FOREIGN SOCIETIES.

London.

CYSTIC DISEASE OF THE LIVER AND KIDNEY—SERTHERAPY OF TYPHOID FEVER—LARGE INTRAHEPATIC CALCULI IN SITU IN A CASE OF DIABETES—CONDITIONS OF THE OCCURRENCE OF LEPROSY IN CHINA AND THE EAST INDIES—PREVENTION OF ENTERIC FEVER.

At a meeting of the Pathological Society, held December 21st, STILL read a paper on a *case of cystic disease of the liver and kidney in an infant eight weeks old*. He discussed the various theories which have been adduced to account for this condition, and particularly combatted that which ascribes the affection to inflammation. Inflammation of the liver would certainly produce jaundice, and further, the resulting fibrosis would be progressive. The case mentioned was without kidney signs of inflammation. The speaker regarded the condition as due to irregular development, there being overgrowth of the mesoblastic elements of the organ which leads to cystic dilation of the tubules and ducts of the kidneys and liver. ROLLESTON said that no theory would be satisfactory which did not also explain the occurrence of cysts in the brain, pancreas, liver, and kidneys, and he still thinks the inflammatory hypothesis the most satisfactory theory which has yet been advanced. PAYNE pointed out that whichever theory is adopted it is clear that the disease must begin at an early period of fetal life. If the ducts were obstructed just before birth there would be definite symptoms just as in the case of biliary cirrhosis. The process must begin before the secreting and excreting parts are connected.

At the meeting of January 4th, JOHNSON related the history of a case of *cystic disease of the kidneys and liver occurring in a woman aged fifty-three years*. Both kidneys were converted into masses of cysts, vary-

ing in size and containing clear or opalescent fluid. The liver was studded throughout with cysts, the largest being the size of a hazelnut. In other respects the liver was normal. The kidneys, however, gave evidence of inflammatory changes, considered by him to be of a secondary character. Johnson thinks that the appearances supported the view expressed by Still at the previous meeting, that the cystic change is to be regarded rather as a developmental error than as a result of inflammation.

At this meeting BOKENHAM gave an account of researches bearing on the *serotherapy of typhoid fever*. While the serotherapy of diphtheria and tetanus depends upon the existence of a true antitoxic function of the remedial serum, no such function has yet been demonstrated as possessed by any known "antityphoid" or "antistreptococcic" serum, their good effects appearing to be due to bactericidal rather than to antitoxic power. Several methods of immunization have been employed; one consists of the use of virulent cultures; another the use of cultures which have been killed either by chloroform or some other antiseptic substance; a third, and the most satisfactory in some respects, consist of the use of filtrates of cultures grown in albuminous broth, and sterilized by heat.

As a result of his experiments upon horses, Bokenham summarizes as follows: (1) Non-toxic filtrates of fresh cultures have distinct immunizing powers; (2) the immunizing action is displayed toward both living and dead cultures; (3) the serum of an animal treated with filtrates of fresh cultures acquires agglutinative and bactericidal properties; (4) mixed with living cultures in sufficient proportion the serum renders them harmless, and (5) to a certain extent the serum has also protective and curative powers.

ROLLESTON showed large *intrahepatic calculi in situ* from a man, aged thirty-eight years, who died of diabetes and pulmonary tuberculosis, and had been jaundiced. It appeared possible that the extension of duodenal catarrh to the pancreatic duct had produced chronic pancreatitis, and that this in turn had caused diabetes. There were no calculi in the gall-bladder, and the cystic duct was not dilated, so that the intrahepatic calculi must have been formed *in situ*. Intrahepatic calculi existing alone and of large size are rare, as is the existence of cholelithiasis in diabetes.

At a meeting of the Epidemiological Society, December 17th, CANTLIE read a paper on the *physical and ethnologic conditions under which leprosy occurs in China, the East-Indian Archipelago, and Oceanica*. In this part of the world leprosy is essentially a Chinese disease, extending from its focus in the south-eastern provinces to every region visited by the lower class of Chinamen, and to no others. The Japanese, Malays, and some Mongolian races suffer in a less degree, but the aborigines, black and brown, have never known the disease, and, indeed, have in their languages no words for it. A rapid encroachment of the sand from the desert on the cultivated northern provinces of Asia drove the sturdy Manchus southwards, crowding out the weaker Chinamen of the south, and compelling them to seek employment

beyond the seas. The coolies belonging to the poorest classes include many actual or incipient lepers who spread the disease in districts in which it was previously unknown, while the Chinese settlers are solely merchants, planters, or tradesmen. In China itself there are distinct leprosy districts, not all of the country being affected. Among the eighteen provinces of the "Middle Kingdom," only six contain such leprosy areas. The women of China are themselves active disseminators of the infection, "selling the disease," as they call it, in the belief that they can free themselves from it by coitus with a healthy man.

The Royal Medical and Chirurgical Society, on January 11th continued the discussion of the *prevention of enteric fever*. (See the MEDICAL NEWS, vol. 72, p. 59.) CORFIELD called attention to the fact that mortality from typhoid fever had been enormously reduced throughout the country since the passing of the Public Health Act of 1875, which led to the wide adoption of water methods in the disposal of feces, including the water-closet. London is probably the one city in all England in which water-closets and water-carriage of sewage are most universal, and the death-rate is less for London than for the whole of England and Wales. On the other hand, mortality is highest in the countries in which the water-system least prevails.

Some curious differences between the spread of typhoid fever and cholera are worth noting. Thus Lyons, France, is a town of cesspools, and typhoid fever is always prevalent there; yet, although cholera has been repeatedly introduced, the disease never spreads, and so well recognized is this fact, that the inhabitants of Paris and Marseilles flee to Lyons in time of danger. In his opinion, the air of the houses becomes contaminated from the underlying cesspools, and so favors the occurrence of typhoid fever. SEATON spoke of the reduction of sixty per cent. which has been effected in the mortality of typhoid fever. He thinks that the fundamental point in the prevention of epidemics is the strengthening of the sanitary authorities. Compulsory notification has proved one of the greatest safeguards in spite of the opposition to its enforcement.

LITTLE recommended for the prevention of typhoid epidemics: (1) universal notification, with compensation to any breadwinner prevented from following his or her occupation; (2) performance of clinical tests, such as Widal's, by the local authorities, free of expense to the medical practitioner; (3) supervision of all public buildings, such as barracks, docks, railway-stations, hospitals, etc., by the local medical health-officer; (4) the water test should be insisted upon before any drains are even permitted; (5) municipal control of the water-supply with right of inspection back to the source; (6) inspection of the sources of the milk-supply; (7) all raw shell-fish should be regarded as "suspected"; (8) all cases should be treated in hospitals, under the charge of their own physicians; and last (9), typhoid excreta should not be applied to the soil.

WILLIAMS remarked that the distinct family proclivity to have the disease must not be lost sight of. In his opinion there is also a distinct race vulnerability, the

Anglo-Saxon people being more prone to contract typhoid fever than the Southern races. He mentioned one town on the Mediterranean in which there are no drains, and the custom of the place is for each inhabitant to deposit his own feces outside the city wall, to be disintegrated by the elements, with the assistance of dogs, birds, and flies, and as yet typhoid fever is there almost unknown. SMITH said that the bacilli are present in the urine and feces for a considerable time after defervescence—at least two to four weeks—and that, therefore, the disinfection of these excrementitious matters ought to be continued throughout the convalescence. Burning is preferable to disinfection with strong antiseptic solutions.

In conclusion POORE said that he did not advocate the abolition of the water-closet in London, but that typhoid stools should be burnt to prevent contamination of the water; and that in the country it is best to put the excreta near the top of tilled humus. Merely digging a trench, filling it with excrement which is then covered with soil, is quite a different matter, and tends to preserve rather than to disintegrate the feces. The method advocated is by no means a new one, as it was commanded by Moses (Deut. xxiii, 13) that every one should go outside the camp to defecate, bearing with him a paddle with which lightly to cover the excrement.

## SOCIETY PROCEEDINGS.

### NORTHWESTERN MEDICAL AND SURGICAL SOCIETY OF NEW YORK.

*Stated Meeting, Held Wednesday, December 15, 1897.*

THE President. CHARLES L. DANA, M.D., in the Chair.

DR. P. C. COLE read the paper of the evening, entitled A CASE OF FEVER WITH INTERCURRENT PLEURO-PNEUMONIA. (See page 236.)

#### DISCUSSION.

DR. SIMON BARUCH: I have so often spoken on this subject that I can add but little to what I have already said. I would, however, like to say that the author lays too much stress upon the fact that the temperature was not reduced until several days after the compresses were first employed. The object of the compress treatment is not the reduction of temperature, which is a secondary consideration in the treatment of infectious diseases. The principal thing is to counteract the toxemia which is overpowering the patient and doing damage to the organs which maintain life. This is accomplished by the action of the compresses on the peripheral cutaneous vessels. Dr. Hutchinson of Buffalo recently read a paper in which he refers to the "skin heart"—a very important discovery, I think. He is an expert in comparative anatomy and physiology, and has traced the skin heart from its rudimentary development and goes on to show that the cutaneous vessels possess the power of contracting and dilating, and that they are supplied with ganglionic centers which control this capacity. This was clinically demonstrated by Romberg some years ago, and by others



since then. In my book it has been shown that the enfeeblement of the heart in infectious diseases is not so much due to failure of this organ—fatty degeneration—but rather to a failure of the cutaneous vessels to aid the circulation of the blood as they normally do. In the normal condition the circulation is maintained by the heart driving the blood into the vessels and capillaries, and the tone or resistance of these vessels furnishes what is known as arterial tension. This arterial tension is interfered with by the spastic contraction of the cutaneous vessels in typhoid fever and other infectious diseases. To overcome this failure of the peripheral vessels is the principal object of the cold compress. I do not use the cold bath in pneumonia because the disturbance which it involves would damage the inflamed lung and pleura. Quite a considerable reduction of temperature in pneumonia will follow even rather high temperature baths, *i.e.*, 85° F.; indeed, they often produce a greater fall than do baths at 65° F. The compress at 60° F., however, is an agent which I have found of value in stimulating the peripheral circulation, and thus enabling the heart to overcome the toxemia, although by this means the temperature is seldom reduced more than a degree or two. The compress treatment, like the Brand treatment of typhoid fever, is for the purpose of carrying the patient through the toxic period of the disease. The history of the case which Dr. Cole has narrated shows very clearly that this was accomplished. The patient did not begin to improve until the fifth or sixth day, when the natural life of the diplococcus ceased. The cold compresses maintained the patient's life until this period arrived—until the poison was eliminated. I like to dwell upon this fact because it is very generally misunderstood by the profession. Cold baths and compresses are not employed as antithermic agents. We have been taught so much about the danger of high temperature that we imagine that all that is necessary is to reduce this. If this were the case, we could accomplish the desired end by the use of antipyrin, and the result would be that the patient would be permitted to die with a normal temperature.

DR. J. H. FRUITNIGHT: I disclaim any criticism of Dr. Cole's diagnosis in the case under discussion, but it seems to me that it was from the commencement one of pneumonia and of a typhoid type. It is quite possible that the physical signs of pneumonia were not present on the first or second day. We observe such cases every day, especially in those in which the pathologic process begins in the center of the lung. I myself had an attack of typhoid-pneumonia which ran a somewhat similar course.

DR. A. R. ROBINSON: I agree with Dr. Fruitnight and believe the case was one of central pneumonia. In regard to the application of cold compresses, I read a paper before this Society fifteen years ago in which I advocated the use of the cold pack, in the manner employed in this case, in the bronchial pneumonia of children. I do not, however, entirely agree with Dr. Baruch in regard to the object gained by cold applications. I am of the opinion that benefit is to be derived from keeping the temperature down below what is clinically regarded as dangerous; nor do I think that all the indications in this affection are

met by cold compresses alone. Treatment in such an infectious disease should be directed also toward elimination, so far as possible, of the toxin which caused the dangerous conditions. Elimination is demanded and this can best be accomplished by way of the kidneys rather than through the intestinal canal. Of course, if we can cause the skin to act also in this direction, so much the better.

DR. ROBERT A. MURRAY: The case is unusually interesting on account of the patient being an opium habitué. I have observed many of these cases, and have noticed that when they are attacked with pneumonia the disease does not frankly declare itself. I have tried to explain this by the fact that the pneumonia was a central one, but I have not always been able to believe that this was the case. The question, in these cases, also arises as to when the use of opium should be stopped. If we discontinue its use the patient is apt to die. Opium with them is a powerful support to the heart, and this is the reason why it is so hard to make them give it up. In treating these patients it is essential that the kidneys be made to act well. These patients should be given quantities of fluid so that the waste products may be washed away. It is also well to give calomel to clear out the intestines. It is a curious fact that many patients with opium-poisoning who are brought to the city hospitals develop a fatal pneumonia. This may be due to the cold effusions which are applied or to the exposure which the patients undergo, but it does seem that there is some relation between opium-poisoning and inflammation of the lungs.

In regard to cold-water applications in the treatment of pneumonia, they stimulate the patient and relieve the contraction of the capillaries, besides reducing the temperature. It is not well, however, to bring down the temperature too quickly. I have noticed that the patient makes a bad convalescence if this is done. I am a firm believer in the stimulating effect of carbonate of ammonia in these cases.

DR. CHARLES L. DANA: The pneumonia of the alcoholic or opium habitué is usually a mixed infection or else one due to the streptococcus; it is rarely croupous pneumonia. The lowered vitality of the patient as well as the intensity and mixture of the infection accounts for the mortality. Infection comes sometimes through the foulness of the mouth and the stuporous condition of the patient, which allows infected matter to penetrate into the lungs and stomach. I have watched and directed many kinds of special treatment for pneumonia in the wards of Bellevue Hospital, and I have found no one method which is superior to any other. The best results have been obtained when the patient had a watchful physician and nurse who met the symptoms as they arose. Oxygen seems to have a symptomatic value. In regard to the case under discussion, I agree with Dr. Fruitnight that it was one of pneumonia in the beginning. The treatment was certainly very successful, but I would not like to say positively that the cold packs saved the man's life, for I have seen recovery in many bad cases of pneumonia without the use of these packs.

DR. JOSEPH COLLINS: I would like to hear a general

expression of opinion of the members of this Society in regard to the use of oxygen in pneumonia. Doubtless there is an opinion abroad that the use of this gas is serviceable, but statistics are more valueless in this respect than in any other. The only way of getting at the facts is by means of personal experience. We have all employed oxygen. I have not only used it but have entirely discarded its employment in pneumonia, neurasthenia, and other diseases; for I regret to say that I have found it utterly worthless. I would like to ask Dr. Cole what his experience with this agent has been.

DR. DANA: There is no question but that oxygen produces good results symptomatically. The patient improves as he inhales it, and this is enough to justify its use. I know of only three remedies which will relieve the patient with pneumonia. One is oxygen; the second is the free use of cups, 80 or 100 being applied to the back; and the third is external applications—such as hot poultices of mustard and flour—which stimulate the circulation. In milder cases the use of stimulants like ammonia will have a good effect, and at times copious bleeding of an almost moribund patient will produce a marked improvement.

DR. L. DUNCAN BULKLEY: Twenty-five years ago, when I was a hospital interne, I had some experience with oxygen. We had an elaborate apparatus and employed it a great deal, but within six months we concluded that we had had enough of it, and its use was discontinued. The immediate results seemed to be good, but there was a disagreeable reaction afterward. In many cases we believed that this reaction was the cause of death. Since then my experience has confirmed this opinion.

DR. FRUITNIGHT: I do not think that oxygen should be discarded because it does not always save life. It gives immediate relief to a patient suffering from severe dyspnea. I have recently used it in two cases with marked benefit in each. At the Children's Hospital of St. John's Guild we have many cases of croupous pneumonia, and it always does good in those in which there is dyspnea and cyanosis. We use it there in combination with digitalis and strychnia.

DR. BARUCH: I used oxygen to a marked extent for eight or ten years, and ceased using it about six years ago. I always employ hydrotherapy in cases of pneumonia. I have the record of a case of pneumonia occurring in a girl eleven years of age, which was seen by Dr. Jacobi. The temperature was 106° F., and the pulse 160. The most powerful stimulants had been employed without effect. I stopped the use of poultices and gave her a full bath with the water at a temperature of 95° F. The temperature fell to 102° F.; she rallied, and the cyanosis, which was due to an enfeebled heart action, disappeared. She made a good recovery, though but two baths were given.

I would like to have the privilege of saying something about the remark made by Dr. Robinson to the effect that elimination is necessary in these cases and that cold compresses alone are not sufficient to meet the indications. The point in regard to elimination is a good

one, but he has lost sight of the fact that baths and the wet pack aid largely in eliminating the poison. A quantity of fluid should also be given. I give my patients plenty of water to drink. I insist upon the administration of six or eight ounces of water every hour, and the same quantity of milk every other hour. It has been clinically demonstrated that the cold bath in typhoid fever increases the amount of urine. I have seen it increase to 120 ounces in the twenty-four hours in a boy of eighteen years suffering from typhoid fever, and it is often increased to sixty or eighty ounces in pneumonia. All these cases are due to infection, and, therefore, elimination should be the chief therapeutic aim. Both theory and practice show that this is accomplished by the treatment I have mentioned, *i. e.*, cold compresses, copious draughts of water, and the administration of strychnia and calomel.

DR. MURRAY: I do not think I could do without digitalis in the treatment of pneumonia. The edema of the lungs is often relieved by hypodermics of this drug. It is an exceedingly powerful agent, and is of great value when the heart is rapidly weakening. Nitroglycerin is of benefit in cases in which there is a cold, clammy perspiration; for it relieves the contraction of the capillaries and stimulates the respiratory circulation. I have been criticised for advocating blood-letting in pneumonia, but in Bellevue Hospital I have seen many lives saved by this procedure. This was accomplished by means of cups, as advised by Dr. Alonzo Clark. My experience has taught me that in pneumonia the symptoms and not the disease must be treated. In some cases I have used the cold bath with good results, and when I could not get the desired effect with this I have employed hot baths at a temperature of 108° to 110° F. Hot flannels applied to the chest are often of benefit in bringing a patient out of a condition of collapse.

DR. ROBERT H. GREENE: I agree with what has been said in condemnation of oxygen. I have employed it in a large number of cases of pneumonia, and have never seen good results follow its use, although it temporarily stimulates the circulation. The circulation afterward becomes more feeble, the month is made dry, and the patient becomes more exhausted. I have used all the heart stimulants, and the one which has given me the best results is musk. The great disadvantage of this drug is that it is very expensive. Personal experience has led me to believe that there is no medicine which has a curative effect in pneumonia. I have not employed cold baths or compresses in treating this disease, but I have used cold water with good results in cases of erysipelas in which the patient was in a condition of systemic toxemia. I am inclined to think that in selected cases, if properly applied, it would be of benefit in pneumonia.

DR. COLE in closing: Dr. Baruch thinks I have laid too much stress upon the reduction of temperature in the case reported. The pack was applied on the evening of the fifth day, and the temperature did not begin to go down until the morning of the eighth day, and did not reach 101° F. until the morning of the thirteenth day.

Dr. Taylor has asked how the pack is changed with-

out disturbing the patient. This is a very simple matter. The patient is rolled over on the side, the pack is removed and a new one applied; the patient is then rolled over on the back and the compress is brought up from each side and fastened over the chest.

In regard to the diagnosis Dr. Fruitnight may be right. The case may have been one of typhoid-pneumonia in the beginning, but there was not the slightest symptom of it until the morning of the fifth day, although the patient had been seen four or five times during each previous twenty-four hours.

I employed oxygen some years ago, but cannot recall ever having obtained any benefit from its use. The after-effects are injurious. When there is cyanosis blood-letting, in my experience, is much more valuable. For years my greatest stand-by in the treatment of pneumonia has been the carbonate of ammonia. During the entire illness the bowels and kidneys should be kept open. In the case reported, in addition to the cold pack, the patient was sponged daily with cold water and then wiped dry, and was given quantities of water and milk. I agree with Dr. Robinson that this constant application of cold reduces the temperature.

More than forty years ago my sister and her husband (in command of his own vessel) were in China. My sister was attacked with pneumonia, and a surgeon from a British man-of-war was called in to attend her. After two- or three-days' attendance he was obliged to leave with his vessel, which had received orders to sail. The next day my sister's extremities, hands and feet, were cold, blue, and she was pulseless. Respiration was hurried and irregular. In desperation my brother-in-law called in a Chinese physician, none other being obtainable. This physician immediately bathed the thorax with hot water and then covered it with leeches, which were allowed to gorge themselves and drop off. My brother-in-law said he counted more than fifty. My sister recovered, and lived more than twenty-five years afterward. The Chinese physician recognized the need of blood-letting in the cyanotic stage of pneumonia, and by its prompt application undoubtedly saved my sister's life. How many of our physicians would have done the same, that is, drawn blood freely from a patient with pneumonia?

**THE NEW YORK ACADEMY OF MEDICINE.—  
SECTION ON OBSTETRICS AND  
GYNECOLOGY.**

*Stated Meeting, Held January 27, 1898.*

SIMON MARX, M.D., Chairman.

THE paper of the evening, entitled

MIDWIVES,

was read by HENRY J. GARRIGUES, M.D. (See page 232.)

**DISCUSSION.**

DR. POLK: In dealing with this question we must regard it from a high standpoint and a high plane. All the rights in the case must be taken into consideration. The people wish an educated service, and this they can

obtain only through physicians, male and female. It seems to me that the duty of this Section is plain; the question is simply, Shall or shall we not have midwives? This is answered by the general feeling which exists throughout the community, in other words, there cannot be too much education; and this being the case, there is no reason why midwives should not be licensed to practise as doctors of medicine; they should be qualified in the usual way, that is, by obtaining a regular medical education.

DR. TUTTLE: I have been asked by the president of the County Society to come here to-night, though I do not understand why, as that body has not taken any action on this subject; therefore, I do not know how to represent it.

If I present my own opinion, I would say that midwives are a menace to public health and life. The women of our households should not, through ignorance, be entrusted in their hour of greatest trial to the hands of incompetent persons. It is no longer believed by any one that it is technically correct to speak of labor as a physiologic process. It is rarely so in the tenement districts of this city. I do not wish to characterize all midwives as immoral. The majority are honest, whole-souled women; but aside from all this the institution of midwives furnishes an opportunity to women of immoral character to enter the occupation of abortionist.

We, as physicians, have some rights; for instance, the right of self-preservation. This question should also be considered from our standpoint—the point of view of the physician. We should insist that the person who delivers our wives and sisters should be educated and competent.

DR. GRANDIN: My individual opinion in this matter is that the profession and the community should realize that the institution of midwives has no right to exist. I question the legality of its existence for the reason that the members of this guild are engaged in the practice of medicine. I take the ground that obstetrics is as much a part of medicine as pediatrics, and that any one wishing to practise midwifery should not be allowed to do so without passing the Regents' examination. The only thing to do in attempting to reform present conditions is to amend existing laws, thus giving midwives the right to practise or else to undertake their education—not in obstetrics alone, but in general medicine and surgery. In my opinion labor cannot be regarded as a physiologic process. Civilization has so altered woman that she is not now what she once was. During labor emergencies and complications may arise which require the judgment of an educated physician. Furthermore, the actual labor is not the only thing to be attended to; long before the advent of the expected confinement the condition of the heart, kidneys, and other organs should be under constant supervision, and such duties no midwife is competent to perform without having a regular medical education.

DR. BOLDT: I am personally in favor of abolishing the institution of midwives, but I am afraid, gentlemen, that unless an unusually strong amount of backing is brought to bear upon the Legislature, we will never be able to carry the point; and I feel we must devise some means to accomplish it gradually, if we wish to succeed at



all. My views are entirely in accord with those of the reader of the paper. I certainly favor entire abolishment.

DR. VINEBERG: I hold a different view from what has been expressed by the majority of the speakers who have preceded me. I was sent here to confer. I should like to ask what opportunity is given to teach doctors to attend midwifery cases. If some of the terrible experiences which occur in the practice of midwives are depicted, why not describe some which occur in the practice of qualified physicians. I believe in thorough education, but not in a three-years' course. Now, for example, let us take a woman in the tenement district; a midwife will talk and wait with her; a qualified physician, under the same circumstances, will apply forceps. I do not think that midwives are a curse as they now exist. It behooves us to educate and to limit them. They cannot apply forceps or sew up a perineum, and they are obliged to send for a physician if they have a difficult case.

DR. GARRIGUES: In closing, I have only a few remarks to make. Most of the gentlemen who have spoken declare themselves in favor of abolishing the institution of midwives. It should be distinctly understood that the only way to obtain what we wish is by means of a law by which we can have supervision over those who are now practising midwifery. I have not said that female physicians would be able to do all the work of the midwives. What I said was that the profession, male and female, could attend to all cases of labor. It is only in cities of large population that midwives flourish. They are not recognized by any general law. I wish to emphasize one more point in regard to the economic side of the question. I have been informed that it is not only the poor who employ midwives, but others as well. Many midwives are paid as high as \$20. The general run of poor people pay the midwife \$5 for her services, and I am sure that there is a number of regular practitioners who would be willing to attend labor cases for that price.

## REVIEWS.

**SURGICAL PATHOLOGY AND PRINCIPLES.** By J. JACKSON CLARKE, M.B., F.R.C.S., Assistant Surgeon at the N. W. London and City Orthopedic Hospitals. With 194 illustrations. London: Longmans Green & Co., 1897.

THE preface informs us that this work is based upon a course of demonstrations given to students. The book is divided into two parts. The first, a general consideration of the surgical principles, and the second, a description of the pathologic processes of the special tissues and organs. The plan adopted is an admirable one. The chapter on diseases of the bone is one of the best.

Whereas the part played by bacteria is not any too strongly emphasized, the clinical features are never lost sight of, and are always harmonized with what is pathologic. Therapeutic measures receive a casual reference. The illustrations throughout are rather conventional.

As a compend of this subject, elaborately treated in other works, this book ought to appeal to the medical student.

## THERAPEUTIC HINTS.

**For Erysipelas.**—The intense burning pain is said to be relieved and the progress of the disease favorably influenced by the use of the following application:

℞ Aristol . . . . . gr. xx  
Collodii . . . . . ℥ i.

M. Sig. Apply freely with a camel's-hair brush over and slightly beyond the inflamed area. This should be renewed as it scales off.

### For Threadworms.

℞ Santonin . . . . . gr. ¾  
Calomel . . . . . gr. iss.

M. Ft. chart. No. I. Sig. Take one powder before breakfast every day for three days.

In addition a small quantity of the following ointment should be introduced into the rectum each night:

℞ Amyli glycerit. . . . . 3 ii  
Ung. hydrarg. . . . . 3 i—m.

### An Ointment for Enlarged Glands.

℞ Ichthyo . . . . . }  
Ung. hydrarg. . . . . } aa . . . . . 3 i  
Ung. belladonnæ . . . . . }  
Ung. petrolati . . . . . ℥ ss.

M. Ft. ung. Sig. Apply night and morning over affected glands using friction till absorbed.

### For Pertussis.

℞ Tr. Belladonnæ . . . . . 3 ss  
Phenacetin . . . . . 3 i gr. xv  
Spts. frumenti . . . . . 3 iv  
Ext. castaneæ fl. . . . . ℥ ii.

M. Sig. To a child over one year of age administer ten drops every two to six hours; for a child of ten years the dose is one teaspoonful.

### For Renal Colic.

℞ Lycetol . . . . . 3 iss  
Sod. bicarb. . . . . gr. xlv.

M. Ft. chart. No. VI. Sig. Take one powder night and morning in a glass of mineral water.

**For Acute Laryngitis.**—After a calomel purge give the following:

℞ Tr. aconiti . . . . . gtt. xii  
Sod. brom. . . . . 3 ii  
Syr. lactucarii . . . . . ℥ i  
Aq. . . . . q. s. ad. 3 iii.

M. Sig. One teaspoonful every four hours.

**For the Insomnia of Senile Dementia** it is recommended to give from eight to sixteen grains of trional in a glass of hot milk at bedtime. A calm sleep of six to nine hours may be expected to follow the use of the drug.

### For Favus.

℞ Sulph. sublimat. . . . . ℥ ss  
Potass. carb. . . . . 3 i  
Ol. picis liq. . . . . }  
Tinct. iodi . . . . . } aa . . . . . 3 iss  
Adipis . . . . . 3 iii.

M. Sig. External use.